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Including Annotations to the Georgia Reports
and the Georgia Appeals Reports

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THIS SUPPLEMENT CONTAINS

Statutes:

All laws specifically codified by the General Assembly of the State of Georgia through the 2012 Regular Session of the General Assembly.

Annotations of Judicial Decisions:

Case annotations reflecting decisions posted to LexisNexis® through March 30, 2012. These annotations will appear in the following traditional reporter sources: Georgia Reports; Georgia Appeals Reports; Southeastern Reporter; Supreme Court Reporter; Federal Reporter; Federal Supplement; Federal Rules Decisions; Lawyers' Edition; United States Reports; and Bankruptcy Reporter.

Annotations of Attorney General Opinions:

Constructions of the Official Code of Georgia Annotated, prior Codes of Georgia, Georgia Laws, the Constitution of Georgia, and the Constitution of the United States by the Attorney General of the State of Georgia posted to LexisNexis® through March 30, 2012.

Other Annotations:

References to:

Emory Bankruptcy Developments Journal.
Emory International Law Review.
Emory Law Journal.
Georgia Journal of International and Comparative Law.
Georgia Law Review.
Georgia State University Law Review.
Mercer Law Review.
Georgia State Bar Journal.
Georgia Journal of Intellectual Property Law.
American Jurisprudence, Second Edition.
American Jurisprudence, Pleading and Practice.
American Jurisprudence, Proof of Facts.
American Jurisprudence, Trials.
Corpus Juris Secundum.
Uniform Laws Annotated.
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Tables:

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ARTICLE 1

AGENTS, AGENCIES, SUBAGENTS, COUNSELORS, AND ADJUSTERS

33-23-1. Definitions.

(a) As used in this article, the term:

(1) "Adjuster" means any individual who for a fee, commission, salary, or other compensation investigates, settles, or adjusts and reports to his or her employer or principal with respect to claims arising under insurance contracts on behalf of the insurer or the insured or a person who directly supervises or manages such individual. The term "adjuster" does not include:

(A) Individuals who adjust claims arising under contracts of life or marine insurance or annuities; or

(B) An agent or a salaried employee of an agent or a salaried employee of an insurer who adjusts or assists in adjusting losses under policies issued by such agent or insurer.

(2) "Agency" means a business entity which represents one or more insurers and is engaged in the business of selling, soliciting, or

negotiating insurance. Agency also means a business entity insurance producer.

(3) “Agent” means an individual appointed or employed by an insurer who sells, solicits, or negotiates insurance. Agent also means an individual insurance producer.

(3.1) “Automated claims adjudication system” means a preprogrammed computer system designed for the collection, data entry, calculation, and final resolution of property insurance claims used only for portable electronics as defined in paragraph (1) of subsection (d) of Code Section 33-23-12 which:

(A) May only be utilized by a licensed independent adjuster, licensed agent, or supervised individuals operating pursuant to this paragraph;

(B) Shall comply with all claims payment requirements of the Georgia Insurance Code; and

(C) Shall be certified as compliant with this Code section by a licensed independent adjuster that is an officer of a business entity licensed under this chapter.

(4) “Business entity” means a corporation, association, partnership, sole proprietorship, limited liability company, limited liability partnership, or other legal entity.

(5) “Controlled business of a person” means property or casualty insurance for a person or a person’s spouse; for any relative by blood or marriage within the second degree of kinship as defined by paragraph (5) of Code Section 53-4-2; for a person’s employer or the firm of which a person is a member; for any officer, director, stockholder, or member of a person’s employer or of any firm of which a person is a partner; for any spouse of the officer, director, employer, stockholder, or member of a person’s firm; for a person’s ward or employee; or for any person or in regard to any property under a person’s control or supervision in any fiduciary capacity.

(6) “Counselor” means any individual who engages or advertises or holds himself or herself out as engaging in the business of counseling, advising, or rendering opinions as to the benefits promised under any contract of insurance issued or offered by any insurer or as to the terms, value, effect, advantages, or disadvantages under the contract of insurance, other than an actuary or consultant advising insurers. When receiving a fee, commission, or other compensation for this service, such individual shall not receive any compensation from any other source on or relating to the same transaction.

(7) “Home state” means Canada, the District of Columbia, and any state or territory of the United States in which an insurance producer

or adjuster maintains his or her principal place of residence or principal place of business and is licensed to act as an insurance producer or adjuster.

(8) "Independent adjuster" means an adjuster representing the interest of the insurer who is not an employee of such insurer.

(9) "Insurance," except where the type of insurance is specifically stated, means all kinds of insurance other than bail bonding by individual sureties.

(10) "Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

(10.1) "Limited subagent" means an individual licensed on behalf of a licensed agent pursuant to Code Section 33-23-12.

(11) "Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms, or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers.

(12) "Person" means an individual or business entity.

(13) "Public adjuster" means any person who solicits, advertises for, or otherwise agrees to represent only a person who is insured under a policy covering fire, windstorm, water damage, and other physical damage to real and personal property other than vehicles licensed for the road, and any such representation shall be limited to the settlement of a claim or claims under the policy for damages to real and personal property, including related loss of income and living expense losses but excluding claims arising out of any motor vehicle accident.

(14) "Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company.

(15) "Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company.

(16) "Subagent" means any licensed agent, except as provided in Code Section 33-23-12, who acts for or on behalf of another licensed agent in the selling of, solicitation of, or negotiation for an insurance contract or annuity contract and who has on file with the Commissioner a certificate of authority from each agent with whom the subagent places insurance. Subagent also means subproducer. The term "subagent" shall not include:

(A) An agent who places insurance with or through another agent involving 12 or fewer policies or certificates of insurance in any one calendar year; or

(B) An agent who places surplus lines insurance with or through a surplus lines broker only with respect to such surplus lines insurance.

(17) "Surplus lines broker" means an individual licensed pursuant to Code Section 33-23-37.

(b) The definitions of agent, subagent, counselor, and adjuster in subsection (a) of this Code section shall not be deemed to include:

(1) An attorney at law admitted to practice in this state, when handling the collections of premiums or advising clients as to insurance as a function incidental to the practice of law or who, from time to time, adjusts losses which are incidental to the practice of his or her profession;

(2) Any representative of ocean marine insurers;

(3) Any representative of farmers' mutual fire insurance companies as defined in Chapter 16 of this title;

(4) A salaried employee of a credit or character reporting firm or agency not engaged in the insurance business who may, however, report to an insurer;

(5) A person acting for or as a collection agency;

(6) A person who makes the salary deductions of premiums for employees or, under a group insurance plan, a person who serves the master policyholder of group insurance in administering the details of such insurance for the employees or debtors of the master policyholder or of a firm or corporation by which the person is employed and who does not receive insurance commissions for such service; provided, further, that an administration fee not exceeding 5 percent of the premiums collected paid by the insurer to the administration office shall not be construed to be an insurance commission;

(7) Persons exempted from licensure as provided in subsection (h) of Code Section 33-23-4; or

(8) An individual who collects claim information from, or furnishes claim information to, insureds or claimants, who conducts data entry, and who enters data into an automated claims adjudication system, provided that the individual is an employee of a licensed independent adjuster or its affiliate where no more than 25 such persons are under the supervision of one licensed independent adjuster or licensed agent. (Code 1981, § 33-23-1, enacted by Ga. L. 1992, p. 2830, § 1;

Ga. L. 1995, p. 1011, §§ 1, 2; Ga. L. 1999, p. 878, § 2; Ga. L. 2001, p. 925, § 1; Ga. L. 2008, p. 1076, § 1/SB 113; Ga. L. 2012, p. 1350, §§ 3, 4, 5/HB 1067; Ga. L. 2012, p. 1040, §§ 4, 5, 6/SB 203.)

The 2008 amendment, effective July 1, 2008, added paragraph (a)(10.1).

The 2012 amendments. — The first 2012 amendment, effective July 1, 2012, in subsection (a), added paragraph (a)(3.1), in paragraph (a)(7), inserted “or adjuster” near the middle, and added “or

adjuster” at the end; and, in subsection (b), deleted “or” at the end of paragraph (b)(6), substituted “; or” for a period at the end of paragraph (b)(7), and added paragraph (b)(8). The second 2012 amendment, effective July 1, 2012, made identical changes.

JUDICIAL DECISIONS

Corporation may not be agent.

Bankruptcy debtors who administered employment benefit plans were fiduciaries for purposes of nondischargeability of debts to the plans under 11 U.S.C. § 523(a)(4) as licensed insurance agents, since O.C.G.A. § 33-23-35(b) created an express statutory trust, and the debtors’

administration of the plans through a corporation did not abrogate their fiduciary status as individuals under O.C.G.A. § 33-23-1. *Nat’l Air Traffic Controllers Assoc. v. Davenport* (In re Davenport), No. 05-76748-MHM, 2007 Bankr. LEXIS 3725 (Bankr. N.D. Ga. Sept. 6, 2007).

33-23-1.1. Counselor’s additional ancillary services considered a separate transaction.

JUDICIAL DECISIONS

Substantive due process claim failed. — Bidding insurer’s summary judgment motion was properly granted as to its substantive due process claim against a county as the county’s decision to throw out the entire bidding process was rational in light of the taint caused by a consultant’s lack of a counselor’s license under O.C.G.A. §§ 33-23-1.1 and 33-23-4. *Benefit Support, Inc. v. Hall County*, 281 Ga. App. 825, 637 S.E.2d 763 (2006), cert. denied, 2007 Ga. LEXIS 214 (Ga. 2007).

Effect of lack of consultant’s license. — Bidding insurer’s summary judgment motion was properly granted as to its equal protection claim against a county as the county did not exercise arbitrary power but acted rationally and reasonably in rejecting all bids across the board after it was discovered that a consultant lacked a counselor’s license under O.C.G.A. §§ 33-23-1.1 and 33-23-4; because of the taint to the process, all bids were rejected, no classification was created at all, and all similarly situated per-

sons were treated alike. *Benefit Support, Inc. v. Hall County*, 281 Ga. App. 825, 637 S.E.2d 763 (2006), cert. denied, 2007 Ga. LEXIS 214 (Ga. 2007).

Damages under O.C.G.A. § 51-1-6. — Summary judgment was properly entered for a consultant and a consulting firm on a bidding insurer’s claim under O.C.G.A. § 51-1-6 after all of the bids for a county contract were rejected because the consultant lacked a license under O.C.G.A. §§ 33-23-1.1 and 33-23-4 as the statutes requiring insurance counselors to be licensed and mandating that licensed individuals meet certain qualifications were designed to protect the insurance counselor’s clients and not to protect or benefit providers of insurance; the generic statement that O.C.G.A. § 33-23-5(a) was “for the protection of the people of (Georgia)” did not expand the intent of the statute requiring licensure for counselors to benefit businesses that provided insurance. *Benefit Support, Inc. v. Hall County*, 281 Ga. App. 825, 637 S.E.2d 763 (2006), cert. denied, 2007 Ga. LEXIS 214 (Ga. 2007).

33-23-3. Agency licensing and biennial renewals; ownership restrictions.

(a) Each principal office and each branch office of an agency as defined in paragraph (2) of subsection (a) of Code Section 33-23-1 must obtain an agency license prior to commencement of operations and renew such license biennially and prior to December 31 by filing application forms prescribed by the Commissioner.

(a.1) All agency licenses that were issued with an expiration date of December 31, 2012, shall expire on that date, but shall be renewed pursuant to subsection (a) of this Code section.

(b) An agency shall be subject to all penalties, fines, criminal sanctions, and other actions authorized for agents under this chapter.

(c) No person shall be an owner of an agency or, if the agency is a corporation, no person shall be an officer or director of such corporation or own 10 percent or more of the corporation if such person has had his or her license under this chapter refused, revoked, or suspended. (Code 1981, § 33-23-3, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1997, p. 1296, § 3; Ga. L. 2001, p. 925, § 1; Ga. L. 2011, p. 623, § 2/SB 251; Ga. L. 2012, p. 37, § 1/HB 477.)

The 2011 amendment, effective May 12, 2011, added “, except as provided by subsection (a.1) of this Code section” at the end of subsection (a), and added subsection (a.1).

The 2012 amendment, effective March 22, 2012, in subsection (a), substituted “biennially and prior to December 31” for “annually” near the middle; deleted “, except as provided by subsection (a.1) of this Code section” at the end following

“the Commissioner”; and substituted the present provisions of subsection (a.1) for the former provisions, which read: “The Commissioner by rule or regulation may provide for the transition from annual renewal to biennial renewal of licenses issued under this Code section by staggering the renewal periods in 2012 and 2013. Certain licenses may be required to renew one year at one-half the biennial fee provided in Code Section 33-8-1.”

33-23-4. License required; restrictions on payment or receipt of commissions; positions indirectly related to sale, solicitation, or negotiation of insurance excluded from licensing requirements.

(a)(1) A person shall not sell, solicit, or negotiate insurance in this state for any class or classes of insurance unless the person is licensed for that line of authority in accordance with this chapter and applicable regulations.

(2) Any individual who sells, solicits, or negotiates insurance in this state must be licensed as an agent.

(3) Any business entity that sells, solicits, or negotiates insurance in this state must be licensed as an agency.

(b) No insurer or agent doing business in this state shall pay, directly or indirectly, any commissions or any other valuable consideration to any person for services as an agent, subagent, or adjuster within this state, unless such person is duly licensed in accordance with this article.

(c) An insurer may pay a commission or other valuable consideration to a licensed insurance agency in which all employees, stockholders, directors, or officers who sell, solicit, or negotiate insurance contracts are qualified insurance agents, limited subagents, or counselors holding currently valid licenses as required by the laws of this state; and an agent, limited subagent, or counselor may share any commission or other valuable consideration with such a licensed insurance agency.

(d) No person other than a duly licensed adjuster, agent, limited subagent, or counselor shall pay or accept any commission or other valuable consideration except as provided in subsections (b) and (c) of this Code section.

(e) This Code section shall not prevent the payment or receipt of renewal or deferred commissions by any agency or a person on the grounds that the licensee has ceased to be an agent, limited subagent, or counselor nor prevent the receipt or payment of any commission by an individual who has been issued a temporary license pursuant to this chapter.

(f) Any individual who has been licensed as an agent for ten consecutive years or more and who does not perform any of the functions specified in paragraph (3) of subsection (a) of Code Section 33-23-1 other than receipt of renewal or deferred commissions shall be exempt from the requirement to maintain at least one certificate of authority; provided, however, that if such individual wishes to again perform any of the other functions specified in said paragraph, such individual must obtain approval from the Commissioner and comply with the requirements of this chapter and applicable rules and regulations, including without limitation the requirements for certificate of authority.

(g) Any person who willfully violates this Code section shall be guilty of a misdemeanor and, upon conviction thereof, shall be subject to punishment as provided in Code Section 17-10-3, relating to punishment for misdemeanors.

(h)(1) Nothing in this article shall be construed to require an insurer to obtain an insurance agent's license. As used in this Code section, the term "insurer" does not include an insurer's officers, directors, employees, subsidiaries, or affiliates.

(2) A license as an insurance agent shall not be required of the following:

(A) An officer, director, or employee of an insurer or of an insurance agent or agency, provided that the officer, director, or employee does not receive any commission on policies written or sold to insure risks residing, located, or to be performed in this state and:

(i) The officer, director, or employee's activities are executive, administrative, managerial, clerical, or a combination of these, and are only indirectly related to the sale, solicitation, or negotiation of insurance;

(ii) The officer, director, or employee's function relates to underwriting, loss control, inspection, or the processing, adjusting, investigating, or settling of a claim on a contract of insurance; or

(iii) The officer, director, or employee is acting in the capacity of a special agent or agency supervisor assisting insurance agents where the person's activities are limited to providing technical advice and assistance to licensed insurance producers and do not include the sale, solicitation, or negotiation of insurance;

(B) A person who meets the criteria set forth in paragraph (6) of subsection (b) of Code Section 33-23-1;

(C) An employer or association or its officers, directors, or employees or the trustees of an employee trust plan to the extent that the employers, officers, employees, directors, or trustees are engaged in the administration or operation of a program of employee benefits for the employer's or association's own employees or the employees of its subsidiaries or affiliates, which program involves the use of insurance issued by an insurer, so long as the employers, associations, officers, directors, employees, or trustees are not in any manner compensated, directly or indirectly, by the company issuing the contracts;

(D) Employees of insurers or organizations employed by insurers who are engaging in the inspection, rating, or classification of risks or in the supervision of the training of insurance agents and who are not individually engaged in the sale, solicitation, or negotiation of insurance;

(E) A person whose activities in this state are limited to advertising without the intent to solicit insurance in this state through communications in printed publications or other forms of electronic mass media whose distribution is not limited to residents of the state, provided that the person does not sell, solicit, or negotiate insurance that would insure risks residing, located, or to be performed in this state;

(F) A person who is not a resident of this state who sells, solicits, or negotiates a contract of insurance for commercial property and casualty risks to an insured with risks located in more than one state insured under that contract, provided that the person is otherwise licensed as an insurance agent to sell, solicit, or negotiate insurance in the state where the insured maintains its principal place of business and the contract of insurance insures risks located in that state; or

(G) A salaried, full-time employee who counsels or advises his or her employer relative to the insurance interests of the employer or of the subsidiaries or business affiliates of the employer provided that the employee does not sell or solicit insurance or receive a commission. (Code 1981, § 33-23-4, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1996, p. 705, § 9; Ga. L. 1997, p. 1296, § 4; Ga. L. 2001, p. 925, § 1; Ga. L. 2008, p. 1076, § 2/SB 113.)

The 2008 amendment, effective July 1, 2008, inserted “limited” preceding “sub-agent” and “subagents” throughout subsections (c) through (e).

JUDICIAL DECISIONS

Equal protection claim. — Bidding insurer’s summary judgment motion was properly granted as to its equal protection claim against a county as the county did not exercise arbitrary power but acted rationally and reasonably in rejecting all bids across the board after it was discovered that a consultant lacked a counselor’s license under O.C.G.A. §§ 33-23-1.1 and 33-23-4; because of the taint to the process, all bids were rejected, no classification was created at all, and all similarly situated persons were treated alike. *Benefit Support, Inc. v. Hall County*, 281 Ga. App. 825, 637 S.E.2d 763 (2006), cert. denied, 2007 Ga. LEXIS 214 (Ga. 2007).

License not required. — District court erred in holding that a plaintiff would not be harmed absent a preliminary injunction barring enforcement of certain restrictive covenants because under Georgia law, a party did not need a license to sell insurance in order to operate an insurance brokerage business and hire others to carry out insurance sales. *MacGinnitie v. Hobbs Group, LLC*, 420 F.3d 1234 (11th Cir. 2005).

Bid preparation costs for unlicensed consultant. — Summary judgment was properly entered for a county on

a bidding insurer’s claim for reimbursement of its bid preparation costs due to the county’s rejection of its bid as no contract was awarded to an unqualified bidder since all the bids were rejected when it was discovered that the county’s consultant lacked an insurance counselor’s license under O.C.G.A. §§ 33-23-1.1 and 33-23-4. *Benefit Support, Inc. v. Hall County*, 281 Ga. App. 825, 637 S.E.2d 763 (2006), cert. denied, 2007 Ga. LEXIS 214 (Ga. 2007).

Damages under O.C.G.A. § 51-1-6. — Summary judgment was properly entered for a consultant and a consulting firm on a bidding insurer’s claim under O.C.G.A. § 51-1-6 after all of the bids for a county contract were rejected because the consultant lacked a license under O.C.G.A. §§ 33-23-1.1 and 33-23-4 as the statutes requiring insurance counselors to be licensed and mandating that licensed individuals meet certain qualifications were designed to protect the insurance counselor’s clients and not to protect or benefit providers of insurance; the generic statement that O.C.G.A. § 33-23-5(a) was “for the protection of the people of (Georgia)” did not expand the intent of the statute requiring licensure for counselors to ben-

efit businesses that provided insurance. Ga. App. 825, 637 S.E.2d 763 (2006), cert. Benefit Support, Inc. v. Hall County, 281 denied, 2007 Ga. LEXIS 214 (Ga. 2007).

33-23-5. Qualifications and requirements for license.

(a) For the protection of the people of this state, the Commissioner shall not issue, continue, or permit to exist any license, except in compliance with this chapter and except as provided in Code Sections 33-23-3, 33-23-4, 33-23-12, 33-23-13, 33-23-14, 33-23-16, 33-23-17, 33-23-29, 33-23-29.1, and 33-23-37. The Commissioner shall not issue a license to any individual applicant for a license who does not meet or conform to qualifications or requirements set forth in paragraphs (1) through (7) of this subsection:

(1) The individual applicant shall be a resident of this state who shall reside and be present within this state for at least six months of every year or an individual whose principal place of business is within this state; provided, however, that in cities, towns, or trade areas, either unincorporated or composed of two or more incorporated cities or towns, located partly within and partly outside this state, requirements as to residence and principal place of business shall be deemed met if the residence or place of business is located in any part of the city, town, or trade area and if the other state in which the city, town, or trade area is located in part has established like requirements as to residence and place of business. The individual applying for an agent, adjuster, or counselor license shall be at least 18 years of age;

(2) If applying for an agent's license for property and casualty insurance, the applicant shall not use or intend to use such license for the purpose of obtaining a rebate or commission upon controlled business; and the applicant shall not in any calendar year effect controlled business that will aggregate as much as 25 percent of the volume of insurance effected by such applicant during such year, as measured by the comparative amounts of premiums;

(3) The individual applicant shall be of good character;

(4) The individual applicant shall pass any written examination required for the license by this article, provided that:

(A) An individual who applies for an insurance agent's license in this state who was previously licensed for the same lines of authority in another state shall not be required to complete any prelicensing education or examination. This exemption shall only be available if the individual is currently licensed in that state or if the application is received within 90 days of the cancellation of the applicant's previous license and if the prior state issues a certification that, at the time of cancellation, the applicant was in good

standing in that state or the state's producer data base records maintained by the National Association of Insurance Commissioners, its affiliates, or subsidiaries indicate that the agent is or was licensed in good standing for the line of authority requested; and

(B) An individual licensed as an insurance agent in another state who moves to this state shall make application within 90 days of establishing legal residence to become a resident licensee pursuant to Code Section 33-23-8. No prelicensing education or examination shall be required of that individual to obtain a license for any line of authority previously held in the prior state except where the Commissioner determines otherwise by rule or regulation;

(5) If applying for a license as counselor, the applicant shall show that he or she either has had five years' experience as an agent, subagent, or adjuster or in some other phase of the insurance business or has sufficient teaching or educational qualifications or experience which, in the opinion of the Commissioner, has qualified the applicant to act as such counselor; and the applicant shall pass such examination as shall be required by the Commissioner unless such applicant is exempted by the Commissioner, based on the applicant's experience and qualifications and pursuant to a regulation adopted by the Commissioner;

(6) If applying for an agent's license, limited subagent's license, or adjuster's license, no applicant shall be qualified therefor or be so licensed unless he or she has successfully completed classroom courses in insurance satisfactory to the Commissioner at a school which has been approved by the Commissioner; and

(7) The Commissioner shall by rule or regulation establish criteria and procedures for the scope of prelicensing requirements and exemptions, if any, to the prelicensing or examination requirements.

(b) An individual who was licensed as an agent, counselor, limited subagent, surplus line broker, or adjuster at the time such individual was employed by the Commissioner and who while so employed was employed in responsible insurance duties as a full-time bona fide employee shall be permitted to reinstate his or her license upon termination of employment if written request is made within 90 days after the date of termination of employment with the Commissioner.

(c) Active licensees who apply for additional licenses and individuals who apply for the reinstatement of a license prior to six months from the license expiration date shall not be required to submit fingerprints pursuant to Code Section 33-23-5.1.

(d) Notwithstanding paragraph (1) of subsection (a) of this Code section, no resident of Canada may be licensed as an independent

adjuster pursuant to this Code section or designate Georgia as his or her home state unless such person has successfully passed the adjuster examination and has complied with other applicable portions of this Code section. (Code 1981, § 33-23-5, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1996, p. 705, § 10; Ga. L. 1997, p. 1296, § 5; Ga. L. 2001, p. 4, § 33; Ga. L. 2001, p. 925, § 1; Ga. L. 2005, p. 60, § 33/HB 95; Ga. L. 2006, p. 652, § 7/HB 1257; Ga. L. 2008, p. 1076, § 3/SB 113; Ga. L. 2009, p. 616, § 1/SB 144; Ga. L. 2012, p. 1040, § 7/SB 203; Ga. L. 2012, p. 1350, § 6/HB 1067.)

The 2006 amendment, effective July 1, 2006, in paragraph (a)(6), substituted “either has had five years’ experience as an” for “has had five years’ experience acting as either” near the beginning, substituted “or has sufficient teaching or educational qualifications or experience which, in the opinion of the Commissioner,” for “which in the opinion of the Commissioner” near the middle; and added “unless the applicant is exempted by the Commissioner, based on the applicant’s experience and qualifications and pursuant to a regulation adopted by the Commissioner” at the end.

The 2008 amendment, effective July 1, 2008, substituted “shall” for “must” throughout the Code section; in paragraph (a)(1), in the first sentence, substituted “shall reside” for “will reside” near the beginning, inserted “that”, substituted “composed of” for “comprised of”, and substituted “this state” for “the state” in the proviso; in paragraph (a)(2), substituted “such license” for “the license” near the beginning; in paragraph (a)(3), substi-

tuted “shall be appointed” for “must have been appointed” and substituted “prior to” for “subject to”; in subparagraph (a)(5)(A), in the second sentence, substituted “shall only be available” for “is only available” near the beginning, and added “and” at the end; in paragraph (a)(6), substituted “such applicant” for “the applicant” near the end; in paragraph (a)(7) and subsection (b), inserted “limited” near the beginning; and added subsection (c).

The 2009 amendment, effective July 1, 2009, in the introductory paragraph of subsection (a), substituted “through (7)” for “through (8)”; deleted former paragraph (a)(3), which read: “If applying for an agent’s license, the applicant shall be appointed an agent by an authorized insurer prior to issuance of the license;”; and redesignated former paragraphs (a)(4) through (a)(8) as present paragraphs (a)(3) through (a)(7), respectively.

The 2012 amendments. — The first 2012 amendment, effective July 1, 2012, added subsection (d). The second 2012 amendment, effective July 1, 2012, made identical changes.

JUDICIAL DECISIONS

Damages under O.C.G.A. § 51-1-6. — Summary judgment was properly entered for a consultant and a consulting firm on a bidding insurer’s claim under O.C.G.A. § 51-1-6 after all of the bids for a county contract were rejected because the consultant lacked a license under O.C.G.A. §§ 33-23-1.1 and 33-23-4 as the statutes requiring insurance counselors to be licensed and mandating that licensed individuals meet certain qualifications were

designed to protect the insurance counselor’s clients and not to protect or benefit providers of insurance; the generic statement that O.C.G.A. § 33-23-5(a) was “for the protection of the people of (Georgia)” did not expand the intent of the statute requiring licensure for counselors to benefit businesses that provided insurance. *Benefit Support, Inc. v. Hall County*, 281 Ga. App. 825, 637 S.E.2d 763 (2006), cert. denied, 2007 Ga. LEXIS 214 (Ga. 2007).

33-23-5.1. Conviction data.

(a) As used in this Code section, the term “conviction data” means a record of a finding or verdict of guilty or plea of guilty or nolo contendere with regard to any crime regardless of whether an appeal of the conviction has been sought.

(b) With respect to the requirements of paragraph (3) of subsection (a) of Code Section 33-23-5, the Commissioner shall be authorized to obtain conviction data with respect to an applicant as authorized in this Code section. The Commissioner shall submit to the Georgia Crime Information Center two complete sets of fingerprints of the applicant for appointment or employment, the required records search fees, and such other information as may be required. Upon receipt of such material, the Georgia Crime Information Center shall promptly forward one set of fingerprints to the Federal Bureau of Investigation for a search of bureau records and the preparation of an appropriate report concerning such records search and shall retain the other set and promptly conduct a search of its own records and all records to which the center has access. The Georgia Crime Information Center shall notify the Commissioner in writing of any derogatory finding, including, but not limited to, any conviction data regarding the fingerprint records check or if there is no such finding. All conviction data received by the Commissioner shall not be a public record, shall be privileged, and shall not be disclosed to any other person or agency except as provided in this Code section and except to any person or agency that otherwise has a legal right to inspect the employment file. All such records shall be maintained by the Commissioner pursuant to the laws regarding such records and the rules and regulations of the Federal Bureau of Investigation and the Georgia Crime Information Center, as applicable. (Code 1981, § 33-23-5.1, enacted by Ga. L. 2008, p. 1076, § 4/SB 113; Ga. L. 2009, p. 616, § 2/SB 144.)

Effective date. — This Code section 1, 2009, substituted “paragraph (3)” for “paragraph (4)” near the beginning of the first sentence of subsection (b).

The 2009 amendment, effective July

33-23-8. Form and contents of license application; fees.

(a) An individual applicant for any license required by this chapter shall file with the Commissioner an application upon forms prescribed by the Commissioner.

(b) If the application is for an agent’s or limited subagent’s license, the application shall state the kinds of insurance proposed to be transacted. If applying as a limited subagent, the applicant shall be appointed as a limited subagent by a sponsoring agent prior to the issuance of such license.

(c) As to any application for a limited subagent's license or certificate of authority, the Commissioner shall require as part of the application a certificate of the sponsoring agent proposed to be represented. The certificate shall state, relative to the applicant's character, including criminal background, identity, residence, experience, and instruction as to the kinds of insurance to be transacted, that the sponsoring agent is satisfied that the applicant is trustworthy and qualified to act as its limited subagent and to hold himself or herself out in good faith to the general public as a limited subagent and the fact that the sponsoring agent desires that the applicant be licensed as a limited subagent to represent it in this state.

(d) Each applicant for an agency license shall file with the Commissioner the information required under Code Section 33-23-3.

(e) All such applications shall be accompanied by the appropriate fees in the respective amounts as provided by law. (Code 1981, § 33-23-8, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1997, p. 1296, § 6; Ga. L. 2001, p. 925, § 1; Ga. L. 2005, p. 60, § 33/HB 95; Ga. L. 2008, p. 1076, § 5/SB 113.)

The 2008 amendment, effective July 1, 2008, in subsection (a), substituted "an application" for "a written application" in the first sentence, and deleted the former second sentence, which read: "The application shall be signed and verified by the oath of the applicant."; rewrote subsection (b); in subsection (c), substituted "a limited subagent's" for "an agent's or subagent's" and deleted "insurer or" preced-

ing "sponsoring agent" in the first sentence, in the second sentence, deleted "insurer or" preceding "sponsoring agent" twice, substituted "limited subagent" for "agent or subagent", substituted "a limited subagent and" for "an agent or subagent, and", and substituted "a limited subagent" for "an agent or subagent" near the end.

33-23-10. Examination of applicants.

(a) Each individual applicant for a license as agent, limited subagent, counselor, adjuster, or surplus line broker shall submit to a personal examination in writing as to his or her competence to act in such capacity. The examination shall be prepared and given by the Commissioner or a designee of the Commissioner and shall be given and graded in a fair and impartial manner and without unfair discrimination as between individuals examined. Any required examination may be supplemented by an oral examination at the discretion of the Commissioner. The Commissioner shall provide by rule or regulation for a reasonable waiting period before giving a reexamination to an applicant who failed to pass a previous similar examination.

(b) The Commissioner shall by rule or regulation establish criteria and procedures for:

- (1) The scope of any examination; and

(2) Exemptions, if any, to examinations, provided that the Commissioner shall not, under any circumstances, exempt himself or herself from any written examination requirements set forth in this Code section.

(c) An applicant for a license to act as an agent, limited subagent, surplus line broker, counselor, or adjuster who held a valid license to act as such which lapsed while the applicant was a member of any branch of the armed forces of the United States shall be granted a new license if application is made within a period of five years from the date of the expiration of the old license and proof satisfactory to the Commissioner is furnished that:

(1) The individual was a member of the armed forces of the United States at the time the previous license lapsed; and

(2) The individual's service in the armed forces of the United States was not terminated more than one year prior to the date of application for a new license. (Code 1981, § 33-23-10, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1; Ga. L. 2008, p. 1076, § 6/SB 113; Ga. L. 2011, p. 449, § 9/HB 413.)

The 2008 amendment, effective July 1, 2008, inserted "limited" in the first sentence of subsection (a), and in the introductory language of subsection (c).

The 2011 amendment, effective July 1, 2011, added the proviso at the end of paragraph (b)(2).

33-23-12. Limited licenses.

(a) Except as provided in subsection (b) of this Code section for credit insurance licenses, subsection (c) of this Code section for rental companies, and subsection (d) of this Code section for portable electronics, the Commissioner may provide by rule or regulation for licenses which are limited in scope to specific lines or sublines of insurance.

(b)(1) Licenses shall be issued to individuals for the purpose of writing credit insurance as provided in this subsection.

(2) Resident applicants must be sponsored by an insurer authorized to write credit insurance in this state, and the applicant must certify that he or she has read and understands the provisions of this title and regulations promulgated pursuant to this title which are pertinent to credit insurance in this state.

(3) Nonresident applicants must follow the appointment process set forth in subsection (g) of Code Section 33-23-16.

(4) No preclicensing education or preclicensing examination shall be required for issuance of such license, and the insurer shall certify that the licensee has completed a minimum of five hours of self-study in credit insurance subjects.

(5) The lines or sublines of insurance included in the scope of authority of credit insurance licenses issued under this Code section shall include, but not be limited to, the following:

- (A) Credit life and credit accident and sickness insurance;
- (B) Credit casualty insurance;
- (C) Credit property insurance;
- (D) Credit unemployment insurance;
- (E) Accidental death and dismemberment insurance;
- (F) Nonfiling or nonrecording insurance;
- (G) Vendors' single interest insurance; and

(H) Any other lines or sublines of insurance which may become accepted as credit insurance by the insurance and lending industries unless otherwise disapproved by the Commissioner.

(c)(1) As used in this subsection, the term:

(A) "Limited licensee" means a person or entity authorized to sell certain coverages relating to the rental of vehicles pursuant to the provisions of this subsection.

(B) "Rental agreement" means any written agreement setting forth the terms and conditions governing the use of a vehicle provided by the rental company for rental or lease.

(C) "Rental company" means any person or entity in the business of providing primarily private passenger vehicles to the public under a rental agreement for a period not to exceed 90 days.

(D) "Rental period" means the term of the rental agreement.

(E) "Renter" means any person obtaining the use of a vehicle from a rental company under the terms of a rental agreement for a period not to exceed 90 days.

(F) "Vehicle" or "rental vehicle" means a motor vehicle of the private passenger type, including passenger vans, minivans, and sport utility vehicles, and of the cargo type, including cargo vans, pick-up trucks, and trucks with a gross vehicle weight of less than 26,000 pounds and which do not require the operator to possess a commercial driver's license.

(2) The Commissioner may issue to a rental company that has complied with the requirements of this subsection a limited license authorizing the limited licensee to offer or sell insurance through a licensed insurer in connection with the rental of vehicles.

(3) As a prerequisite for issuance of a limited license under this subsection, there shall be filed with the Commissioner an application for a limited license in such form or forms, and supplements thereto, and containing such information as the Commissioner may prescribe.

(4) In the event that any provision of this subsection is violated by a limited licensee, the Commissioner may:

(A) After notice and a hearing, revoke or suspend a limited license issued under this subsection in accordance with the provisions of Code Sections 33-23-21 and 33-23-22; or

(B) After notice and a hearing, impose such other penalties, including suspending the transaction of insurance at specific rental locations where violations of this subsection have occurred, as the Commissioner deems to be necessary or convenient to carry out the purposes of this subsection.

(5) The rental company licensed pursuant to paragraph (2) of this subsection may only offer or sell insurance through licensed insurers in connection with and incidental to the rental of vehicles, whether at the rental office or by preselection of coverage in an individual, master, corporate, or group rental agreement, in any of the following general categories:

(A) Personal accident insurance covering the risks of travel, including, but not limited to, accident and health insurance that provides coverage, as applicable, to renters and other rental vehicle occupants for accidental death or dismemberment and reimbursement for medical expenses resulting from an accident that occurs during the rental period;

(B) Liability insurance, which, at the exclusive option of the rental company, may include uninsured and underinsured motorist coverage, whether offered separately or in combination with other liability insurance, that provides coverage, as applicable, to renters and other authorized drivers of rental vehicles for liability arising from the operation of the rental vehicle;

(C) Personal effects insurance that provides coverage, as applicable, to renters and other rental vehicle occupants for the loss of, or damage to, personal effects that occurs during the rental period;

(D) Roadside assistance and emergency sickness protection programs; and

(E) Any other travel or vehicle related coverage that a rental company offers in connection with and incidental to the rental of vehicles.

(6) No insurance shall be offered by a limited licensee pursuant to this subsection unless:

(A) The rental period of the rental agreement does not exceed 90 consecutive days;

(B) At every rental location where rental agreements are executed, brochures or other written materials are readily available to the prospective renter that:

(i) Summarize clearly and correctly the material terms of coverage offered to renters, including the identity of the insurer;

(ii) Disclose that such policies offered by the rental company may provide a duplication of coverage already provided by a renter's personal automobile insurance policy, homeowner's insurance policy, personal liability insurance policy, or other source of coverage;

(iii) State that the purchase by the renter of the kinds of coverage specified in this subsection is not required in order to rent a vehicle; and

(iv) Describe the process for filing a claim in the event the renter elects to purchase coverage and in the event of a claim;

(C) Evidence of coverage on the face of the rental agreement is disclosed to every renter who elects to purchase such coverage.

(7) Any limited license issued under this subsection shall also authorize any employee of the limited licensee to act individually on behalf and under the supervision of the limited licensee with respect to the kinds of coverage specified in this subsection.

(8) Each rental company licensed pursuant to this subsection shall provide a training program in which employees being trained by a licensed instructor receive basic insurance instruction about the kinds of coverage specified in this subsection and offered for purchase by prospective renters of rental vehicles. Additionally, each rental company shall provide for such employees two hours of continuing education courses annually to be taught by a licensed instructor. A rental company shall certify that, prior to offering such coverages, each employee has received such instruction.

(9) Notwithstanding any other provision of this subsection or any rule adopted by the Commissioner, a limited licensee pursuant to this subsection shall not be required to treat moneys collected from renters purchasing such insurance when renting vehicles as funds received in a fiduciary capacity, provided that the charges for coverage shall be itemized and be ancillary to a rental transaction. The sale of insurance not in conjunction with a rental transaction shall not be permitted.

(10) No limited licensee under this subsection shall advertise, represent, or otherwise hold itself or any of its employees out as licensed insurers, insurance agents, or insurance brokers.

(d)(1) As used in this subsection, the term:

(A) "Customer" means a person who purchases portable electronics or services.

(B) "Enrolled customer" means a customer who elects coverage under a portable electronics insurance policy issued to a vendor of portable electronics.

(C) "Location" means any physical location in the State of Georgia or any website, call center site, or similar location directed to residents of the State of Georgia.

(D) "Portable electronics" means handsets, pagers, personal digital assistants, portable computers, automatic answering devices, cellular telephones, batteries, and other similar devices and their accessories and includes services related to the use of such devices, including, but not limited to, individual customer access to a wireless network.

(E) "Portable electronics insurance" means insurance providing coverage for the repair or replacement of portable electronics which may provide coverage for portable electronics against any one or more of the following causes of loss: loss, theft, inoperability due to mechanical failure, malfunction, damage, or other similar causes of loss. Such term shall not include a service contract or extended warranty providing coverage limited to the repair, replacement, or maintenance of property in cases of operational or structural failure due to a defect in materials, workmanship, accidental damage from handling power surges, or normal wear and tear.

(F) "Portable electronics transaction" means the sale or lease of portable electronics by a vendor to a customer or the sale of a service related to the use of portable electronics by a vendor to a customer.

(G) "Supervising entity" means a business entity that is a licensed insurer, or insurance producer that is authorized by licensed insurer, to supervise the administration of a portable electronics insurance program.

(H) "Vendor" means a person in the business of engaging in portable electronics transactions directly or indirectly.

(2) The commissioner may issue to a retail vendor of portable electronics that has complied with the requirements of this subsec-

tion a limited license authorizing the limited licensee to offer or sell portable electronics insurance policies.

(3) A limited license issued under this subsection shall authorize any employee or authorized representative of the vendor to sell or offer coverage under a policy of portable electronics insurance to customers at each location where the vendor engages in portable electronics transactions.

(4) The supervising entity shall maintain a registry of vendor locations that are authorized to sell or solicit portable electronics insurance coverage in this state. Upon request by the commissioner and with ten days notice to the supervising entity, the registry shall be open to inspection and examination by the commissioner during regular business hours of the supervising entity.

(5) The sale of such insurance policies shall be limited to sales in connection with the sale of or provision of service for portable electronics by the retail vendor.

(6) At every location where portable electronics insurance is offered to customers, brochures or other written materials shall be made available to a prospective customer which:

(A) State that the enrollment by the customer in a portable electronics insurance program is not required in order to purchase or lease portable electronics or services;

(B) Summarize the material terms of the insurance coverage, including:

(i) The identity of the insurer;

(ii) The identity of the supervising entity;

(iii) The amount of any applicable deductible and how it is to be paid;

(iv) Benefits of the coverage; and

(v) Key terms and conditions of coverage such as whether portable electronics may be repaired or replaced with a similar make and model or with reconditioned or nonoriginal manufacturer parts or equipment;

(C) Summarize the process for filing a claim, including a description of how to return portable electronics and the maximum fee applicable in the event the customer fails to comply with any equipment return requirements; and

(D) State that an enrolled customer may cancel enrollment for coverage under a portable electronics insurance policy at any time

and the person paying the premium shall receive a refund of any applicable unearned premium.

(7) Portable electronics insurance may be offered on a month-to-month or other periodic basis as a group or master commercial inland marine policy issued to a vendor of portable electronics for its enrolled customers. Coverage under portable electronics insurance shall be primary to any other insurance.

(8) Eligibility and underwriting standards for customers electing to enroll in coverage shall be established for each portable electronics insurance program.

(9) Notwithstanding any other provision of law, employees or authorized representatives of a vendor of portable electronics shall not be compensated based primarily on the number of customers enrolled for portable electronics insurance coverage but may receive compensation for activities under the limited license which are incidental to their overall compensation.

(10) The charges for portable electronics insurance coverage may be billed and collected by the vendor of portable electronics. Any charge to the enrolled customer for coverage that is not included in the cost associated with the purchase or lease of portable electronics or related services, shall be separately itemized on the enrolled customer's bill. If the portable electronics insurance coverage is included with the purchase or lease of portable electronics or related services, the vendor shall clearly and conspicuously disclose to the enrolled customer that the portable electronics insurance coverage is included with the portable electronics or related services. Vendors billing and collecting such charges shall not be required to maintain such funds in a segregated account, provided that the vendor is authorized by the insurer to hold such funds in an alternative manner and remits such amounts to the supervising entity within 60 days of receipt. All funds received by a vendor from an enrolled customer for the sale of portable electronics insurance shall be considered funds held in trust by the vendor in a fiduciary capacity for the benefit of the insurer. Vendors may receive compensation for billing and collection services.

(11) As a prerequisite for issuance of a limited license under this subsection, there shall be filed with the Commissioner an application for such limited license or licenses in a form and manner prescribed by the Commissioner. The application shall provide:

(A) The name, residence address, and other information required by the Commissioner of an employee or officer of the vendor that is designated by the applicant as the person responsible for the vendor's compliance with the requirements of this subsection;

(B) If the vendor derives more than 50 percent of its revenue from the sale of portable electronics insurance, the information required by subparagraph (A) of this paragraph for all officers, directors, and shareholders of record having beneficial ownership of 10 percent or more of any class of securities registered under the federal securities law; and

(C) The location of the applicant's home office.

(12) The employees and authorized representatives of vendors may sell or offer portable electronics insurance to customers and shall not be subject to licensure as an insurance producer under this Code section, provided that the supervising entity supervises the administration of a training program in which employees and authorized representatives of a vendor shall be trained and receive basic insurance instruction about the kind of coverage authorized in this subsection and offered for purchase by prospective purchasers. The training required by this subsection may be provided in electronic form. However, if provided in electronic form, the supervising entity shall implement a supplemental education program regarding the portable electronics insurance that is conducted and overseen by a licensed instructor.

(13) No prelicensing examination shall be required for issuance of such license.

(14) If a vendor or its employee or authorized representative violates any provision of this subsection, the commissioner may impose any of the following penalties:

(A) After notice and hearing, fines not to exceed \$500.00 per violation or \$5,000.00 in the aggregate for such conduct;

(B) After notice and hearing, other penalties that the commissioner deems necessary and reasonable to carry out the purpose of this article, including:

(i) Suspending the privilege of transacting portable electronics insurance pursuant to this subsection at specific business locations where violations have occurred; and

(ii) Suspending or revoking the ability of individual employees or authorized representatives to act under the license;

(15) Notwithstanding any other provision of law:

(A) An insurer may terminate or otherwise change the terms and conditions of a policy of portable electronics insurance only upon providing the policyholder and enrolled customers with at least 60 days notice;

(B) If the insurer changes the terms and conditions, then the insurer shall provide the vendor with a revised policy or endorsement and each enrolled customer with a revised certificate, endorsement, updated brochure, or other evidence indicating a change in the terms and conditions has occurred and a summary of material changes;

(C) Notwithstanding paragraph (15) of subsection (a) of this Code section, an insurer may terminate an enrolled customer's enrollment under a portable electronics insurance policy upon 15 days notice for discovery of fraud or material misrepresentation in obtaining coverage or in the presentation of a claim;

(D) Notwithstanding paragraph (15) of subsection (a) of this Code section, an insurer may immediately terminate an enrolled customer's enrollment under a portable electronics insurance policy:

(i) For nonpayment of premium;

(ii) If the enrolled customer ceases to have an active service with the vendor of portable electronics; or

(iii) If the enrolled customer exhausts the aggregate limit of liability, if any, under the terms of the portable electronics insurance policy and the insurer sends notice of termination to the enrolled customer within 30 calendar days after exhaustion of the limit. However, if notice is not timely sent, enrollment shall continue notwithstanding the aggregate limit of liability until the insurer sends notice of termination to the enrolled customer; and

(E) Where a portable electronics insurance policy is terminated by a policyholder, the vendor shall mail or deliver written notice to each enrolled customer advising the enrolled customer of the termination of the policy and the effective date of termination. The written notice shall be mailed or delivered to the enrolled customer at least 30 days prior to the termination.

(16) Whenever notice or correspondence with respect to a policy of portable electronics insurance is required pursuant to this subsection or is otherwise required by law, it shall be in writing and sent within the notice period, if any, specified within the statute or regulation requiring the notice or correspondence. Notwithstanding any other provision of law, notices and correspondence may be sent either by mail or by electronic means as set forth in this subparagraph. If the notice or correspondence is mailed, it shall be sent to the vendor of portable electronics at the vendor's mailing address specified for such purpose and to its affected enrolled customers' last known mailing

addresses on file with the insurer. The insurer or vendor of portable electronics, as the case may be, shall maintain proof of mailing in a form authorized or accepted by the United States Postal Service or other commercial mail delivery service. If the notice or correspondence is sent by electronic means, it shall be sent to the vendor of portable electronics at the vendor's electronic mail address specified for such purpose and to its affected enrolled customers' last known electronic mail address as provided by each enrolled customer to the insurer or vendor of portable electronics, as the case may be. For purposes of this paragraph, an enrolled customer's provision of an electronic mail address to the insurer or vendor of portable electronics, as the case may be, shall be deemed as consent to receive notices and correspondence by electronic means. The insurer or vendor of portable electronics, as the case may be, shall maintain proof that the notice or correspondence was sent.

(17) Notice or correspondence required by this subsection or otherwise required by law may be sent on behalf of an insurer or vendor, as the case may be, by the supervising entity appointed by the insurer.

(e)(1) As used in this subsection, the term:

(A) "Limited licensee" means an owner authorized to act as an agent of an insurance provider for purposes of selling certain insurance coverages for personal property maintained in self-service storage facilities pursuant to the provisions of this subsection.

(B) "Occupant" means a person, his or her sublessee, successor, or assign entitled to the use of the storage space at a self-service storage facility under a rental agreement, to the exclusion of others.

(C) "Owner" means the owner, operator, lessor, or sublessor of a self-service storage facility, his or her agent, or any other person authorized by him or her to manage the self-service storage facility or to receive rent from an occupant under a rental agreement.

(D) "Personal property" means movable property not affixed to land and includes, but is not limited to, goods, wares, merchandise, motor vehicles, watercraft, and household items and furnishings.

(E) "Rental agreement" means any agreement or lease, written or oral, that establishes or modifies the terms, conditions, rules, or any other provisions concerning the use and occupancy of a self-service storage facility.

(F) "Self-service storage facility" means any real property designed and used for the purpose of renting or leasing individual

storage space to occupants who are to have access to such for the purpose of storing and removing personal property. No occupant shall use a self-service storage facility for residential purposes. A self-service storage facility is not a warehouse within the meaning of Article 1 of Chapter 4 of Title 10, the "Georgia State Warehouse Act." A self-service storage facility is not a safe-deposit box or vault maintained by banks, trust companies, or other financial entities.

(2) The Commissioner may issue to an owner that is in compliance with the requirements of this subsection a limited license authorizing the limited licensee to offer or sell insurance through a licensed insurer in connection with a self-service storage facility.

(3) A limited licensee shall be authorized to offer or sell insurance on behalf of a licensed insurer only in connection with a rental agreement and only for either an individual policy issued to an individual occupant or as a group policy for occupants for personal property insurance. A limited licensee shall only be authorized to provide to occupants insurance coverage for:

(A) The loss of or damage to personal property stored at a self-service storage facility where the loss or damage occurs at such self-service storage facility during the occupant's rental agreement; or

(B) Such other loss directly related to an occupant's rental agreement.

(4) No insurance shall be issued pursuant to this subsection unless the limited licensee provides to a prospective occupant written material that:

(A) Provides a summary of the terms of insurance coverage, including the identity of the insurer;

(B) Conspicuously discloses that the policy of insurance may provide a duplication of coverage already provided by an existing policy of insurance;

(C) Describes the process for filing a claim in the event the occupant elects to purchase coverage and experiences a covered loss;

(D) Provides information regarding the price, deductible, benefits, exclusions, conditions, and any other limitations of such policy;

(E) States that the limited licensee is not authorized to evaluate the adequacy of the occupant's existing insurance coverages, unless such limited licensee is otherwise licensed; and

(F) States that the occupant may cancel the insurance at any time, and any unearned premium will be refunded in accordance with applicable law.

(5) Notwithstanding any other provision of this subsection or any rule adopted by the Commissioner, a limited licensee licensed pursuant to this subsection shall not be required to treat moneys collected from occupants under rental agreements as funds received in a fiduciary capacity, provided that the charges for coverage shall be itemized and be ancillary to a rental agreement. The sale of insurance not in conjunction with a rental agreement shall not be permitted.

(6) Any limited license issued under this subsection shall also authorize any employee of the limited licensee to act individually on behalf and under the supervision of the limited licensee with respect to the kinds of coverage specified in this subsection.

(7) Each owner licensed pursuant to this subsection shall provide a training program in which employees and authorized representatives of such owner shall be trained by a licensed instructor and receive basic insurance instruction about the kind of coverage authorized in this subsection and offered for purchase by prospective occupants.

(8) As a prerequisite for issuance of a limited license under this subsection, there shall be filed with the Commissioner an application for a limited license in such form or forms, and supplements thereto, and containing such information as the Commissioner may prescribe.

(9) In the event that any provision of this title is violated by a limited licensee, or an employee of a limited licensee, the limited licensee shall be subject to all penalties, fines, criminal sanctions, and other actions authorized by this title.

(10) No prelicensing examination shall be required for issuance of a limited license pursuant to this subsection. (Code 1981, § 33-23-12, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1995, p. 437, § 3; Ga. L. 1999, p. 878, § 4; Ga. L. 2001, p. 4, § 33; Ga. L. 2001, p. 925, § 1; Ga. L. 2002, p. 1047, § 1; Ga. L. 2008, p. 1076, § 7/SB 113; Ga. L. 2012, p. 757, § 1/HB 463; Ga. L. 2012, p. 1040, §§ 2, 3/SB 203; Ga. L. 2012, p. 1350, §§ 1, 2/HB 1067.)

The 2008 amendment, effective July 1, 2008, in paragraph (c)(3), substituted “an application for a limited license in such form” for “a written application for a limited license, signed by an officer of the applicant, in such form” near the middle; in paragraph (c)(5), in the introductory language, inserted “only” near the beginning, and deleted “only” preceding “in connection” near the middle; in subparagraph (c)(5)(A), inserted commas preceding and following “but not limited”; in subparagraph (c)(5)(B), inserted a comma follow-

ing “coverage”; in paragraph (c)(6), substituted “shall be” for “may be” in the introductory language; in paragraph (c)(7), deleted commas preceding and following “and under the supervision”; in paragraph (d)(1), substituted “means” for “shall mean” near the beginning, and inserted a comma following “devices” near the end; in paragraph (d)(2), substituted “may issue to a retail vendor of communications equipment that has complied with the requirements of this subsection a limited license authorizing the limited li-

censee to offer or sell” for “shall issue limited licenses to each business location of a retail vendor of communications equipment which covers employees and authorized representatives of such retail vendors for the sale and offer for sale of”; in paragraph (d)(4), substituted “an application for such limited license or licenses in a form and manner prescribed by the Commissioner” for “a written application for such limited license, signed by the applicant or an officer of the applicant, on such form or forms, and supplements thereto, and containing such information

as the Commissioner may prescribe”; and, in paragraph (d)(5), substituted “such retail vendor shall be” for “the retail vendor are” near the middle.

The 2012 amendments. — The first 2012 amendment, effective July 1, 2012, added subsection (e). The second 2012 amendment, effective July 1, 2012, substituted “portable electronics” for “communications equipment” in subsection (a) and rewrote subsection (d). The third 2012 amendment, effective July 1, 2012, made identical changes as those made by the second 2012 amendment.

33-23-13. Temporary licenses.

(a) In the event of the death of an agent or limited subagent, including a temporary agent or limited subagent, or the inability to act as an agent or limited subagent by reason of service in the armed services of the United States, illness or other disability, or termination of appointment by the insurer, if there is no other individual connected with the agency who is licensed as an agent or limited subagent in regard to insurance of the classification transacted by the agent or limited subagent deceased or unable to act, the Commissioner may issue a temporary license as agent or limited subagent in regard to insurance of such classification to an employee of the agency, to a member of the family of said former agent or limited subagent, or to some associate or to a guardian, receiver, executor, or administrator for the purpose of continuing or winding up the business affairs of the agent, limited subagent, or agency. A temporary license shall be issued only to an applicant who has filed a sworn application upon forms prescribed by the Commissioner. The applicant shall not be required to meet the requirements as to examination, residence, and education required for licensing of agents or limited subagents other than temporary agents. If the Commissioner deems the applicant to be qualified for a temporary license, the Commissioner shall issue the license.

(b) A temporary license may be issued to an individual at the request of an insurer for the purposes of training such individual to act as an agent; provided, however, such individual must perform his or her duties under the supervision of an individual licensed under this article. The Commissioner may prescribe by rules or regulations such further restrictions on such temporary licenses as may be necessary for the protection of the public.

(c) A license issued pursuant to this Code section shall be effective for six months, renewable from time to time for renewal periods of three

months in the discretion of the Commissioner; but in no event shall such renewal or any other temporary license of renewal with reference to the same matter extend to a time more than 15 months after the date of the first issuance of a temporary license in such matter.

(d) A temporary license issued pursuant to subsection (a) of this Code section shall authorize the negotiation of renewal policies, the receipt and collection of premiums, and such other acts as are necessary to the continuance of the particular insurance business of the agent or limited subagent. The license shall not authorize the holder thereof to sell, solicit, or negotiate new insurance accounts.

(e) As to any application for a temporary agent's license pursuant to subsection (b) of this Code section, the Commissioner shall require as part of the application a certificate of the insurer proposed to be represented. The certificate shall state, relative to the applicant's character, including criminal background, identity, residence, experience, and instruction as to the kinds of insurance to be transacted, that the insurer is satisfied that such applicant is trustworthy and qualified to act as its temporary agent and to hold himself or herself out in good faith to the general public as a temporary agent and the fact that the insurer desires that the applicant be licensed as a temporary agent to represent it in this state. (Code 1981, § 33-23-13, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1; Ga. L. 2005, p. 60, § 33/HB 95; Ga. L. 2008, p. 1076, § 8/SB 113.)

The 2008 amendment, effective July 1, 2008, inserted "limited" preceding "sub-agent" or "subagents" throughout subsection (a), and once in the first sentence of subsection (d); and added subsection (e).

33-23-16. Licensing of nonresidents.

(a) Unless denied licensure pursuant to Code Section 33-23-21, a nonresident person shall receive a nonresident agent's license if:

(1) The person is currently licensed as a resident and in good standing in such person's home state;

(2) The person has submitted the proper request for licensure and has paid the fees required by Code Section 33-8-1;

(3) The person has submitted or transmitted to the Commissioner the application for licensure that the person submitted to such person's home state or, in lieu of the same, a completed uniform application or a form prescribed by the Commissioner by rule or regulation for licensure of nonresident agents; and

(4) The person's home state awards nonresident agent licenses to residents of this state on the same basis.

(b) The Commissioner may verify the agent's licensing status through the producer data base maintained by the National Association of Insurance Commissioners, its affiliates, or subsidiaries.

(c) A nonresident agent who moves from one state to another state or a resident agent who moves from this state to another state shall file a change of address and provide certification from the new resident home state within 30 days of the change in legal residence. No fee or application is required.

(d) Notwithstanding any other provision of this title, a person licensed as a surplus lines broker in such person's home state shall receive a nonresident surplus lines broker license pursuant to subsection (a) of this Code section. Except as to subsection (a) of this Code section, nothing in this Code section otherwise amends or supersedes any portion of this title.

(e) Notwithstanding any other provision of this title, a person licensed as a limited lines credit insurance or other type of limited lines agent in such person's home state shall receive a nonresident limited lines agent license pursuant to subsection (a) of this Code section granting the same scope of authority as granted under the license issued by the agent's home state. For the purposes of this subsection, limited lines insurance is any authority granted by the home state which restricts the authority of the license to less than the total authority prescribed in the associated major lines pursuant to applicable Georgia regulations.

(f) The Commissioner may by rule or regulation implement a renewal process and set expiration dates.

(g)(1) A nonresident individual agent shall not act as an agent of an insurer unless the agent becomes an appointed agent of that insurer as follows:

(A) To appoint an individual as its agent, the appointing insurer shall file, pursuant to Code Section 33-23-26, a notice of appointment within 15 days from the date of licensure or before the first insurance application is submitted. An insurer may also elect to appoint an agent to all or some insurers within the insurer's holding company system or group by the filing of a single appointment request;

(B) Upon receipt of the notice of appointment, the Commissioner shall verify within a reasonable time, not to exceed 30 days, that the insurance agent is eligible for appointment. If the insurance agent is determined to be ineligible for appointment, the Commissioner shall notify the insurer within five days of such determination; and

(C) An insurer shall pay an appointment fee, in the amount and method of payment set forth in Code Section 33-8-1, for each insurance agent appointed by the insurer.

(2) An insurer shall remit, in a manner prescribed by the Commissioner, a renewal appointment fee in the amount as provided for initial appointments set forth in Code Section 33-8-1.

(3) An agent who is not acting as an agent of an insurer is not required to become appointed.

(h) Applicants whose home state does not require a license to transact business may be licensed in this state, provided that the applicant takes the examination issued by the Commissioner where required pursuant to this chapter and the applicant submits written documentation from his or her resident state demonstrating the lack of licensing requirement and the state's reciprocity with residents from this state. If the resident state does not license independent adjusters, the independent adjuster shall designate as his or her home state any state in which the independent adjuster is licensed and in good standing. (Code 1981, § 33-23-16, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1; Ga. L. 2005, p. 60, § 33/HB 95; Ga. L. 2012, p. 1040, § 8/SB 203; Ga. L. 2012, p. 1350, § 7/HB 1067.)

The 2012 amendments. — The first 2012 amendment, effective July 1, 2012, added the second sentence in subsection (h). The second 2012 amendment, effective July 1, 2012, made identical changes.

33-23-18. Issuance of license on biennial basis; filing for renewal; continuing education requirements; transition from annual renewal to biennial renewal.

(a) All resident agent, limited subagent, adjuster, and counselor licenses, with the exception of temporary or probationary licenses, shall be issued on a biennial basis and shall expire on the last day of the licensee's birth month, except as provided in subsection (c.1) of this Code section.

(b) Resident agent, limited subagent, adjuster, and counselor licenses may be renewed upon receipt by the Commissioner of evidence of such continuing education as the Commissioner may establish by rule or regulation and payment of such fees as are provided by law.

(c) Renewal of the license on forms prescribed by rule or regulation must be made prior to the last day of the licensee's birth month and biennially thereafter, except as provided in subsection (c.1) of this Code section.

(c.1) All licenses that expire on December 31, 2012, shall be transitioned to a biennial term and shall expire on the last day of the

licensee's birth month, provided that, during the transition, the Commissioner may, as provided by rule or regulation, renew such licenses for a term greater or shorter than the biennial term and may prorate the license renewal fees.

(d) Continuing education requirements imposed by the Commissioner pursuant to this Code section shall not exceed 15 classroom hours for each licensed individual who has held a license for less than 20 years during the year. For those individuals who have held a license for 20 years or more, the requirement shall be no more than ten classroom hours during the year. However, the Commissioner may provide by rule or regulation for continuing education requirements on a biennial basis.

(e) Any individual who has been licensed as an agent for ten consecutive years or more and who does not perform any of the functions specified in paragraph (3) of subsection (a) of Code Section 33-23-1 other than receipt of renewal or deferred commissions shall be exempt from continuing education requirements; provided, however, that if such individual wishes to again perform any of the other functions specified in said paragraph, such individual must obtain approval from the Commissioner and comply with the requirements of this chapter, including without limitation the requirements for continuing education. The Commissioner may provide, by rule or regulation, for any other exemption to or reduction in continuing education required under this Code section.

(f) Every individual required to participate in a continuing education program pursuant to this Code section, or such individual's insurer, shall furnish the Commissioner such information as the Commissioner deems necessary to verify compliance with the continuing education requirements.

(g) The Commissioner by rule or regulation may establish the following:

(1) Staggered deadlines for the filing of forms for renewal of licenses and the corresponding required fees; and

(2) Penalties and procedures for licensees who fail to comply with subsection (c) of this Code section. (Code 1981, § 33-23-18, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1996, p. 705, § 11; Ga. L. 2001, p. 925, § 1; Ga. L. 2005, p. 60, § 33/HB 95; Ga. L. 2008, p. 1076, § 9/SB 113; Ga. L. 2011, p. 623, § 3/SB 251; Ga. L. 2012, p. 37, § 2/HB 477.)

The 2008 amendment, effective July 1, 2008, inserted "limited" preceding "sub-agent" near the beginning of subsections (a) and (b).

The 2011 amendment, effective May

12, 2011, added ", except as provided in subsection (h) of this Code section" at the end of subsection (c); added the last sentence of subsection (d); and added subsection (h).

The 2012 amendment, effective March 22, 2012, in subsection (a), substituted “biennial basis and shall expire on the last day of the licensee’s birth month, except as provided in subsection (c.1) of this Code section” for “continuous basis”; in subsection (b), substituted “Resident” for “Such resident” at the beginning and substituted “renewed” for “continued” near the middle; substituted the present provisions of subsection (c) for the former provisions, which read: “Filings for continuation of the license on forms prescribed by rule or regulation must be made prior to the first December 31 following the initial issuance of the license and every December 31 thereafter, except as provided in subsection (h) of this Code sec-

tion.”; added subsection (c.1); in subsection (d), deleted “calendar” preceding “year” in the first and second sentences; in subsection (f), substituted “Code section, or” for “Code section shall furnish or” and inserted a comma following “insurer” near the middle; in paragraph (g)(1), substituted “renewal” for “continuation”; and deleted former subsection (h), which read: “The Commissioner by rule or regulation may provide for the transition from annual renewal to biennial renewal of licenses issued under this Code section by staggering the renewal periods in 2012 and 2013. Certain licenses may be required to renew one year at one-half the biennial fee provided in Code Section 33-8-1.”

33-23-19. Placing of license on inactive status; subsequent revocation.

(a) An agent’s license shall be placed on inactive status when the agent no longer has on file with the Commissioner a certificate of authority to represent at least one insurer licensed to do business in this state.

(b) When a license is placed on inactive status under this Code section, the agent shall be prohibited from selling, soliciting, or negotiating insurance.

(c) During the time a license is in inactive status under the provisions of this Code section, the licensee still shall be required to provide evidence of compliance with the continuing education requirements of Code Section 33-23-18. (Code 1981, § 33-23-19, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1; Ga. L. 2008, p. 1076, § 10/SB 113.)

The 2008 amendment, effective July 1, 2008, substituted the present provisions of subsection (b) for the former provisions, which read: “When a license placed on inactive status under this Code section has been in such status for two

consecutive years without a certificate of authority having been filed with and accepted by the Commissioner, such license may be revoked without further notice or hearing.”

33-23-20. Effect of license suspension or placement of license on inactive status.

(a) The suspension of the license of an agent or limited subagent or the placing of such license on inactive status shall not deprive such individual or the executors or administrators of such individual’s estate of any right that may have been acquired by a contract made before such suspension or placement on inactive status to receive all or a

portion of commissions upon contracts of insurance written before such suspension or placement on inactive status with reference to the periods of time during which such contracts are in effect, including renewal option periods provided in the contracts.

(b) In case of a sale of an agency upon a work-out basis, the vendor without maintaining his or her license or the executors and administrators of the vendor's estate may participate in the proceeds of premiums on insurance written by the purchaser of the agency when and as authorized to do so by the contract of sale of the agency; and this participation may be without limitation of time after the vendor ceased to hold a license. An agent whose license has been suspended or placed in inactive status may, when the countersignature of a resident licensed agent is required pursuant to Code Section 33-3-26 and if authorized by the insurer, countersign certificates and endorsements necessary to continue coverage to the expiration date, including renewal option periods.

(c) Nothing in this article shall be construed to permit an agent or limited subagent whose license has been suspended or placed in inactive status to sell, solicit, or negotiate insurance other than as expressly permitted in subsections (a) and (b) of this Code section. (Code 1981, § 33-23-20, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1999, p. 878, § 5; Ga. L. 2001, p. 925, § 1; Ga. L. 2005, p. 60, § 33/HB 95; Ga. L. 2008, p. 1076, § 11/SB 113.)

The 2008 amendment, effective July 1, 2008, inserted "limited" preceding "sub-agent" near the beginning of subsections (a) and (c).

33-23-23. Limitation on application after refusal or revocation of license; effect of surrender of license under written consent order.

(a) No licensee or applicant whose license or application has been refused or revoked as provided by Code Sections 33-23-21 and 33-23-22 shall be entitled to file another application for a license as an agent, agency, limited subagent, surplus lines broker, counselor, or adjuster within five years from the effective date of the refusal, revocation, or, if judicial review of such refusal or revocation is sought, within five years from the date of the final court order or decree affirming such refusal or revocation.

(b) The application when filed may be refused by the Commissioner unless the applicant shows good cause why the refusal or revocation of the license shall not be deemed a bar to the issuance of a new license.

(c) By law, any surrender of a license under written consent order shall have the same effect as a revocation under subsections (a) and (b) of this Code section. (Code 1981, § 33-23-23, enacted by Ga. L. 1992, p.

2830, § 1; Ga. L. 1997, p. 1296, § 9; Ga. L. 2001, p. 925, § 1; Ga. L. 2008, p. 1076, § 12/SB 113.)

The 2008 amendment, effective July 1, 2008, inserted “limited” preceding “sub-agent” near the middle of subsection (a).

33-23-25. Place of business.

Every licensed agent, limited subagent, counselor, and adjuster shall have and maintain in this state or, if a nonresident licensee, in the state of domicile, a place of business accessible to the public. The place of business shall be that wherein the licensee principally conducts transactions pursuant to the license. The address of the place of business shall be maintained by the Commissioner. All resident and nonresident licensees shall promptly notify the Commissioner in writing within 30 days of any change in the business address. (Code 1981, § 33-23-25, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1; Ga. L. 2006, p. 652, § 8/HB 1257; Ga. L. 2008, p. 1076, § 13/SB 113.)

The 2006 amendment, effective July 1, 2006, in the third sentence substituted “shall be maintained by the Commissioner” for “shall appear on all licenses of the resident licensee”.

The 2008 amendment, effective July 1, 2008, inserted “limited” preceding “sub-agent” in the first sentence.

33-23-26. Agent’s certificate of authority.

(a) Each insurer authorized to transact insurance in this state shall obtain an agent’s certificate of authority for each agent representing such insurer in the selling, soliciting, or negotiating of contracts of insurance in this state. For the purposes of this subsection, the insurer will be deemed to have obtained a certificate of authority for its designated agent immediately upon submission of the appointment request to the Commissioner; provided, however, that the initial certificate of authority for an applicant for licensure shall not become effective until the date such applicant is finally granted a license by the Commissioner.

(b) All agents’ certificates of authority shall be renewed by the insurer in such form and manner as the Commissioner may prescribe by rule or regulation.

(c) The fee for each agent’s certificate of authority or renewal thereof shall be as provided in Code Section 33-8-1.

(d) An insurer or authorized representative of the insurer that terminates the appointment, employment, contract, or other insurance business relationship with an agent shall notify the Commissioner

within 30 days following the effective date of the termination, using a format prescribed by the Commissioner, if the reason for the termination is one of the reasons set forth in Code Section 33-23-21 or the insurer has knowledge that the agent was found to have engaged in any of the activities in Code Section 33-23-21 by a court, governmental body, or self-regulatory organization authorized by law. Upon the written request of the Commissioner, the insurer shall provide additional information, documents, records, or other data pertaining to the termination or activity of the agent.

(e) If an agent's certificate of authority is terminated, the insurer promptly shall give notice of said termination and the effective date of the termination to the Commissioner and to the agent where reasonably possible. The Commissioner may also require the insurer to demonstrate to the satisfaction of the Commissioner that the insurer has made a reasonable effort to give notice to the agent.

(f) An insurer or authorized representative of the insurer that terminates the appointment, employment, or contract with an agent for any reason not set forth in Code Section 33-23-21 shall notify the Commissioner within 30 days following the effective date of the termination, using a format prescribed by the Commissioner. Upon written request of the Commissioner, the insurer shall provide additional information, documents, records, and other data pertaining to such termination.

(g) The insurer or the authorized representative of the insurer shall promptly notify the Commissioner in a format acceptable to the Commissioner if, upon further review or investigation, the insurer discovers additional information that would have been reportable to the Commissioner in accordance with subsection (d) of this Code section had the insurer known of its existence.

(h) No certificate of authority shall be required for an agent who places surplus lines insurance with or through a surplus lines broker only with respect to such surplus lines insurance.

(i) As to any application for an agent's certificate of authority, the Commissioner shall require as part of the application a certificate of the insurer proposed to be represented. The certificate shall state, relative to the applicant's character, including criminal background, identity, residence, experience, and instruction as to the kinds of insurance to be transacted, that the insurer or sponsoring agent is satisfied that such applicant is trustworthy and qualified to act as its agent in this state. (Code 1981, § 33-23-26, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1993, p. 702, § 2; Ga. L. 2001, p. 925, § 1; Ga. L. 2005, p. 60, § 33/HB 95; Ga. L. 2008, p. 1076, § 14/SB 113.)

The 2008 amendment, effective July 1, 2008, added subsection (i).

33-23-28. Scope of subagent's authority; record of transactions.

(a) A subagent's certificate of authority shall not cover any kind of insurance for which the sponsoring agent and subagent are not licensed.

(b) A subagent or limited subagent shall not have power to bind an insurer.

(c) All business transacted by a subagent under such subagent's license or limited subagent shall be in the name of the agent by whom the subagent or limited subagent is employed; and the agent shall be responsible for all the acts or omissions of the subagent or limited subagent within the scope of his or her employment.

(d) A record of each transaction shall be maintained by both the agent and the subagent or limited subagent. (Code 1981, § 33-23-28, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1999, p. 878, § 6; Ga. L. 2001, p. 925, § 1; Ga. L. 2008, p. 1076, § 15/SB 113.)

The 2008 amendment, effective July 1, 2008, inserted "or limited subagent" once in subsection (b), three times in subsection (c), and once in subsection (d).

33-23-29. Authority of agent to act as adjuster; nonresident adjusters; reciprocal agreements.

(a) On behalf of and as authorized by an insurer for which he or she is licensed as agent, an agent may from time to time act as an adjuster and investigate and report upon claims without being required to be licensed as an adjuster.

(b) No license by this state shall be required:

(1) Of a nonresident independent adjuster for the adjustment in this state of a single loss or of losses arising out of a catastrophe common to all such losses; or

(2) Of a nonresident adjuster who regularly adjusts in another state and who is licensed in such other state, if such state requires a license, to act as adjuster in this state for emergency insurance adjustment work for a period not exceeding 60 days and performed for an employer who is an insurance adjuster licensed by this state or who is a regular employer of one or more insurance adjusters licensed by this state, provided that the employer shall furnish to the Commissioner a notice in writing immediately upon the beginning of the emergency insurance adjustment work. The Commissioner may by rule or regulation establish criteria and procedures for adjusters operating under this Code section.

(c) An individual residing in another state may be licensed by the Commissioner as a nonresident adjuster under the following circumstances and in the following manner:

(1) Upon written application and payment of the required license fee and without requiring a written examination, the Commissioner shall issue a license to an individual to act as a nonresident adjuster if the individual is licensed in his or her home state as an adjuster;

(2) The required fee for the license shall be the fee provided by law or the sum which is charged as a license fee for nonresident adjusters by the state of the applicant's residence, whichever is greater; and

(3) Applicants whose home state does not require a license to transact business may be licensed in this state, provided that the applicant takes the examination issued by the Commissioner where required pursuant to this chapter and the applicant submits written documentation from such applicant's resident state demonstrating the lack of licensing requirements in such state and such state's reciprocity with residents of this state.

(d) The Commissioner shall issue a license to an individual to act as a nonresident adjuster if, by the laws of the state of the applicant's residence, residents of this state may be licensed as nonresident adjusters in the same manner.

(e) The Commissioner is authorized to enter into reciprocal agreements with the appropriate official of any other jurisdiction for the purpose of implementing this Code section.

(f) No resident of Canada may be licensed as a nonresident independent adjuster unless such person has obtained a resident or home state independent adjuster license. (Code 1981, § 33-23-29, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1; Ga. L. 2008, p. 1076, § 16/SB 113; Ga. L. 2012, p. 1040, § 9/SB 203; Ga. L. 2012, p. 1350, § 8/HB 1067.)

The 2008 amendment, effective July 1, 2008, added the last sentence of paragraph (b)(2).

The 2012 amendments. — The first

2012 amendment, effective July 1, 2012, added subsection (f). The second 2012 amendment, effective July 1, 2012, made identical changes.

33-23-30. Restrictions on signing by agents.

Law reviews. — For annual survey on administrative law, see 61 Mercer L. Rev. 1 (2009).

33-23-34. Records of transactions.

(a) Every agent, limited subagent, counselor, and adjuster under this chapter shall keep at the address as shown on his or her license or at the insurer's regional or home office situated in this state a record of all transactions consummated under such license. The record shall be in organized form and shall include:

(1) In the case of an agent or limited subagent, a record of each insurance contract procured or issued together with the names of the insurers and insureds, the amount of premium paid or to be paid, and a statement of the subject of the insurance; and the names of any other licensees from whom business is accepted and of persons to whom commissions or allowances of any kind are promised or paid;

(2) In the case of an adjuster, a record of each investigation or adjustment undertaken or consummated and a statement of any fee, commission, or other compensation received or to be received by the adjuster on account of the investigation or adjustment; and

(3) Such other and additional information as may be customary or as may be reasonably required by the Commissioner.

(b) All records as to any particular transaction shall be kept for a term of five years beginning immediately after the completion of the transaction or the term of the contract, whichever is greater, provided that records of losses adjusted by an independent adjuster may be kept at the office of the insurer for whom the adjuster acted.

(c) In the case of agents or limited subagents, the maintaining of the records required by this Code section at the insurance agency licensed under this chapter for which agency the transaction was undertaken shall be deemed to comply with the requirements of subsection (a) of this Code section. (Code 1981, § 33-23-34, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1997, p. 1296, § 11; Ga. L. 1999, p. 878, § 10; Ga. L. 2001, p. 925, § 1; Ga. L. 2008, p. 1076, § 17/SB 113.)

The 2008 amendment, effective July 1, 2008, inserted "limited" near the beginning of the introductory language of sub-

section (a), in paragraph (a)(1), and subsection (c).

33-23-35. Reporting and disposition of premiums.

(a) An agent, limited subagent, or any other representative of an insurer or of any other person in the effectuation of an insurance contract shall report to the insurer or its agent the premium for the contract and the amount shall be shown in the contract. Each willful violation of this subsection shall constitute a misdemeanor.

(b) All funds representing premiums received or return premiums due the insured by any agent or subagent shall be accounted for in the licensee's fiduciary capacity, shall not be commingled with the licensee's personal funds, and shall be promptly accounted for and paid to the insurer, insured, or agent as entitled to such funds. Nothing contained in this Code section shall be deemed to require any agent or subagent to maintain a separate bank deposit for the funds of each principal, if the funds so held for each principal are reasonably ascertainable from the books of accounts and records of the agent or subagent.

(c) Any violation of this Code section shall constitute grounds or cause for action by the Commissioner, including, but not limited to, probation, suspension, or revocation of the license. Each and every act by a licensee shall also constitute grounds for fines and penalties, which amounts shall be set by rule or regulation of the Commissioner. Any willful violation of this Code section shall constitute a misdemeanor unless such amounts involved exceed \$500.00, whereby such violation shall constitute a felony. (Code 1981, § 33-23-35, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1; Ga. L. 2008, p. 1076, § 18/SB 113.)

The 2008 amendment, effective July 1, 2008, inserted "limited" preceding "sub-

agent" near the beginning of the first sentence in subsection (a).

JUDICIAL DECISIONS

Fiduciary status of agents. — Bankrupt debtors who administered employment benefit plans were fiduciaries for purposes of nondischargeability of debts to the plans under 11 U.S.C. § 523(a)(4) as licensed insurance agents, since O.C.G.A. § 33-23-35(b) created an express statutory trust, and the debtors' adminis-

tration of the plans through a corporation did not abrogate their fiduciary status as individuals under O.C.G.A. § 33-23-1. *Nat'l Air Traffic Controllers Assoc. v. Davenport* (In re Davenport), No. 05-76748-MHM, 2007 Bankr. LEXIS 3725 (Bankr. N.D. Ga. Sept. 6, 2007).

33-23-37. Licensing of surplus lines broker; application; bond; written examination.

(a) Nothing in this chapter shall prevent the placing of surplus lines of insurance when authorized and permitted under this title.

(b) Any person, while licensed as a resident agent as to property, casualty, and surety insurance and who is deemed by the Commissioner to be competent and trustworthy, may be licensed as a surplus lines broker as follows:

(1) Application to the Commissioner for the license shall be on forms furnished by the Commissioner;

(2) The license fee shall be in an amount as provided in Code Section 33-8-1;

(3) Each license shall be issued on a biennial basis and shall expire on the last day of the licensee's birth month and may be renewed by filing an application and paying the prescribed fee in accordance with this Code section except as provided in paragraph (3.1) of this subsection;

(3.1) All licenses that expire on December 31, 2012, shall be transitioned to a biennial term, provided that, during the transition, the Commissioner may, as provided by rule or regulation, renew such licenses for a term greater or shorter than the biennial term and may prorate the license renewal fees;

(4) Prior to the issuance of the license or any renewal of the license, the applicant shall file a bond with the Commissioner or his or her successor in office, for the benefit of any person injured by the violation of the conditions provided in this paragraph. The bond shall be executed by the applicant as principal and by a corporate surety authorized to do business in this state and shall be in the penal sum of \$50,000.00, conditioned that the applicant will comply with the following:

(A) Place insurance only in compliance with Code Section 33-5-25;

(B) Remit promptly the taxes provided in Code Section 33-5-31;

(C) Account to any person requesting him or her to obtain insurance for funds or premiums collected in connection with such insurance; and

(D) Otherwise conduct business in accordance with this title.

The bond shall not be terminated unless prior to such termination 30 days' written notice is filed with the Commissioner; and

(5) Each applicant for a license to act as a surplus lines broker shall submit to a personal written examination to determine his or her competence, unless the applicant is licensed as a surplus lines broker in his or her home state. (Code 1981, § 33-23-37, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1; Ga. L. 2011, p. 623, § 4/SB 251; Ga. L. 2012, p. 37, § 3/HB 477.)

The 2011 amendment, effective May 12, 2011, added "except as provided in paragraph (3.1) of this subsection" at the end of paragraph (b)(3); and added paragraph (b)(3.1).

The 2012 amendment, effective March 22, 2012, in paragraph (b)(3), substituted "issued on a biennial basis and shall expire on the last day of the licensee's birth month" for "issued for a term

expiring on December 31 next following the date of issuance" and deleted "annually" following "renewed"; and substituted the present provisions of paragraph (b)(3.1) for the former provisions, which read: "The Commissioner by rule or regulation may provide for the transition from annual renewal to biennial renewal of licenses issued under this Code section by staggering the renewal periods in 2012

and 2013. Certain licenses may be re- biennial fee provided in Code Section
quired to renew one year at one-half the 33-8-1.”

33-23-38. Placing insurance beyond scope of license or with nonlicensed insurers prohibited; restrictions on sharing commissions; penalty for violation.

(a) No agent or limited subagent shall place any insurance or receive any remuneration in regard to any insurance of a classification outside the scope of such agent’s or limited subagent’s license, nor shall the agent or limited subagent share a commission except with an agent licensed pursuant to this article; with an agency that has as its proprietor or as a partner in the agency or as an officer or employee of the agency one or more agents licensed in regard to insurance that is within the scope of his or her agency; or with an agent or agency having a residence or situs in another state and a license from such other state for the transaction of insurance in that state.

(b) Except as otherwise provided in this title, no person shall solicit or be instrumental in placing insurance upon any risk having a situs in this state except with an insurer admitted to do insurance business in this state.

(c) A violation of this Code section shall authorize, among other penalties, the revocation of the violator’s license as an agent or subagent. (Code 1981, § 33-23-38, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1; Ga. L. 2008, p. 1076, § 19/SB 113.)

The 2008 amendment, effective July 1, 2008, inserted “limited” three times in subsection (a).

RESEARCH REFERENCES

Am. Jur. Pleading and Practice Forms. — 1B Am. Jur. Pleading and Practice Forms, Agency, § 146.

33-23-41. Liability and penalties for unauthorized acts.

Any person who in this state acts, purports to act, or holds himself or herself out as an agent, limited subagent, counselor, or adjuster or as an employee of an agent, limited subagent, counselor, or adjuster of or for an insurer that has not obtained from the Commissioner a certificate of authority then in effect to do business in this state as required by this title or who has not obtained a certificate of authority as required by this article and any person who in this state collects or forwards any premium or portion of the premium for or to the insurer shall pay a sum equal to the state, county, and municipal taxes and license fees required

to be paid by the insurance companies legally doing business in this state. It is the Commissioner's duty to report violators of this Code section to the district attorney for the county in which the violations occurred. Violators of this Code section shall also be personally liable to the same extent as the insurer upon every contract of insurance made by the insurer with reference to a risk having a situs in this state, if the violator participated in the solicitation, negotiation, or making of the contract or in any endorsement to the contract, in any modification of the contract, or in the collection or forwarding of any premium or portion of the premium relating to such contract. This Code section shall have no application to a contract of insurance entered into in accordance with Chapter 5 of this title. (Code 1981, § 33-23-41, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1; Ga. L. 2008, p. 1076, § 20/SB 113.)

The 2008 amendment, effective July 1, 2008, inserted "limited" preceding "sub-agent" twice in the first sentence of this Code section.

33-23-43. Authority of adjusters; penalty for violation.

(a) An adjuster licensed as both an independent and a public adjuster shall not represent both the insurer and the insured in the same transaction.

(b) An adjuster shall have authority under his or her license only to investigate, settle, or adjust and report to his or her principal upon claims arising under insurance contracts on behalf of insurers only if licensed as an independent adjuster or on behalf of insureds only if licensed as a public adjuster.

(c) No public adjuster, at any time, shall knowingly:

(1) Suggest or advise the employment of or name for employment a specific attorney or attorneys to represent a person in any matter relating to a person's potential claims, including any motor vehicle accident claims for personal injury, loss of consortium, property damages, or other special damages;

(2) Accept or agree to accept any money or other compensation from an attorney or any person acting on behalf of an attorney which the adjuster knows or should reasonably know is payment for the suggestion or advice by the adjuster to seek the services of the attorney or for the referral of any portion of a person's claim to the attorney;

(3) Hire or procure another to do any act prohibited by this subsection; or

(4) Advertise or promise to pay or rebate all or any portion of any insurance deductible as an inducement to the sale of goods or

services. As used in this subsection, the term “promise to pay or rebate” includes (A) granting any allowance or offering any discount against the fees to be charged, including, but not limited to, an allowance or discount in return for displaying a sign or other advertisement at the insured’s premises, or (B) paying the insured or any person directly or indirectly associated with the property any form of compensation, gift, prize, bonus, coupon, credit, referral fee, or other item of monetary value for any reason.

(d) For purposes of subsection (c) of this Code section, the term “public adjuster” shall include licensed public adjusters as defined by Code Section 33-23-1, persons representing themselves to be public adjusters who are not properly licensed by the Commissioner, and persons committing any act under paragraph (4) of subsection (c) of this Code section.

(e) Any person who violates any provision of subsection (c) of this Code section shall be guilty of a misdemeanor and such violation shall be grounds for suspension or revocation of licenses under this chapter. (Code 1981, § 33-23-43, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1; Ga. L. 2011, p. 613, § 2/HB 423.)

The 2011 amendment, effective July 1, 2011, deleted “or” from the end of paragraph (c)(2); substituted “; or” for a period at the end of paragraph (c)(3); added paragraph (c)(4); and, in subsection (d), substi-

tuted “33-23-1,” for “33-23-1 and”, substituted “Commissioner, and persons committing any act under paragraph (4) of subsection (c) of this Code section” for “Commissioner” at the end.

ARTICLE 2

LICENSING OF ADMINISTRATORS

33-23-100. (Effective January 1, 2013. See note.) Definitions; exemptions; applicability of Code Sections 33-24-59.5 and 33-24-59.14.

(a) As used in this article, the term:

(1) “Administrator” means any business entity that, directly or indirectly, collects charges, fees, or premiums; adjusts or settles claims, including investigating or examining claims or receiving, disbursing, handling, or otherwise being responsible for claim funds; or provides underwriting or precertification and preauthorization of hospitalizations or medical treatments for residents of this state for or on behalf of any insurer, including business entities that act on behalf of a single or multiple employer self-insurance health plan or a self-insured municipality or other political subdivision. Licensure is also required for administrators who act on behalf of self-insured plans providing workers’ compensation benefits pursuant to Chapter

9 of Title 34. For purposes of this article, each activity undertaken by the administrator on behalf of an insurer or the client of the administrator is considered a transaction and is subject to the provisions of this title.

(2) "Business entity" means a corporation, association, partnership, sole proprietorship, limited liability company, limited liability partnership, or other legal entity.

(3) "Standard financial quarter" means a three-month period ending on March 31, June 30, September 30, or December 31 of any calendar year.

(b) Notwithstanding the provisions of subsection (a) of this Code section, the following are exempt from licensure so long as such entities are acting directly through their officers and employees:

(1) An employer on behalf of its employees or the employees of one or more subsidiary or affiliated corporations of such employer;

(2) A union on behalf of its members;

(3) An insurance company licensed in this state or its affiliate unless the affiliate administrator is placing business with a nonaffiliate insurer not licensed in this state;

(4) An insurer which is not authorized to transact insurance in this state if such insurer is administering a policy lawfully issued by it in and pursuant to the laws of a state in which it is authorized to transact insurance;

(5) A life or accident and sickness insurance agent or broker licensed in this state whose activities are limited exclusively to the sale of insurance;

(6) A creditor on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors;

(7) A trust established in conformity with 29 U.S.C. Section 186 and its trustees, agents, and employees acting thereunder;

(8) A trust exempt from taxation under Section 501(a) of the Internal Revenue Code and its trustees and employees acting thereunder or a custodian and its agents and employees acting pursuant to a custodian account which meets the requirements of Section 401(f) of the Internal Revenue Code;

(9) A bank, credit union, or other financial institution which is subject to supervision or examination by federal or state banking authorities;

(10) A credit card issuing company which advances for and collects premiums or charges from its credit card holders who have autho-

rized it to do so, provided that such company does not adjust or settle claims;

(11) A person who adjusts or settles claims in the normal course of his or her practice or employment as an attorney and who does not collect charges or premiums in connection with life or accident and sickness insurance coverage or annuities;

(12) An insurance company licensed in this state or its affiliate if such insurance company or its affiliate is solely administering limited benefit insurance. For the purpose of this paragraph, the term "limited benefit insurance" means accident or sickness insurance designed, advertised, and marketed to supplement major medical insurance and specifically shall include accident only, CHAMPUS supplement, disability income, fixed indemnity, long-term care, or specified disease insurance; or

(13) An association that administers workers' compensation claims solely on behalf of its members.

(c) A business entity claiming an exemption shall submit an exemption notice on a form provided by the Commissioner. This form must be signed by an officer of the company and submitted to the department by December 31 of the year prior to the year for which an exemption is to be claimed. Such exemption notice shall be updated in writing within 30 days if the basis for such exemption changes. An administrator claiming an exemption pursuant to paragraphs (3) and (4) of subsection (b) of this Code section shall be subject to the provisions of Code Sections 33-24-59.5 and 33-24-59.14.

(d) Obtaining a license as an administrator does not exempt the applicant from other licensing requirements under this title.

(e) Obtaining a license as an administrator subjects the applicant to the provisions of Code Sections 33-24-59.5 and 33-24-59.14.

(f) An administrator shall be subject to Code Sections 33-24-59.5 and 33-24-59.14 unless the administrator provides sufficient evidence that the self-insured health plan failed to properly fund the plan to allow the administrator to pay any outside claim. (Code 1981, § 33-23-100, enacted by Ga. L. 1991, p. 1403, § 1; Ga. L. 2005, p. 563, § 7/HB 407; Ga. L. 2011, p. 595, § 4/HB 167.)

Delayed effective date. — This Code section, as set forth above, is effective on January 1, 2013. For the version of this Code section effective until that date, see the bound volume.

The 2011 amendment, effective January 1, 2013, in paragraph (a)(1), in the first sentence, substituted "or provides

underwriting" for "and provides underwriting", inserted "a single or", substituted "self-insurance health plan or a self-insured municipality or other political subdivision" for "self-insurance health plans, and self-insured municipalities or other political subdivisions"; added paragraph (a)(3); substituted "so long as" for

“as long as” in the introductory paragraph of subsection (b); substituted the present provisions of paragraph (b)(12) for the former provisions, which read: “A business entity that acts solely as an administrator of one or more bona fide employee benefit plans established by an employer or an employee organization, or both, for whom the insurance laws of this state are preempted pursuant to the federal Em-

ployee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq.; or”; added the last sentence in subsection (c); and added subsections (e) and (f).

Editor’s notes. — Ga. L. 2011, p. 595, § 1, not codified by the General Assembly, provides that: “This Act shall be known and may be cited as the ‘Insurance Delivery Enhancement Act of 2011.’”

CHAPTER 24

INSURANCE GENERALLY

Article 1		Sec.	
General Provisions			
Sec.			
33-24-3.	Insurable interest — Personal insurance.	33-24-56.3.	ing or nonpreferred providers of health care services. Colorectal cancer screening and testing.
33-24-6.	Consent of insured to insurance contract; exceptions; reliance by insurer on statements in application.	33-24-56.4.	Payment for telemedicine services.
33-24-6.1.	Prerequisites for replacement life insurance exceeding insurance being surrendered.	33-24-58.2.	Newborn Baby and Mother Protection Act — Minimum health benefit policy coverage; prohibited actions by insurance providers; required notice to mother.
33-24-16.1.	Clarification of term “actual charge” or “actual fee”.	33-24-59.2.	Coverage for equipment and self-management training for individuals with diabetes; enforcement.
33-24-19.1.	Certificate of insurance forms to be approved by Commissioner; definitions; required provisions of certificate.	33-24-59.5.	(Effective January 1, 2013. See note.) Definitions; timely payment of health benefits; notification of failure to pay; penalties; applicability.
33-24-21.1.	Group accident and sickness contracts; conversion privilege and continuation right provisions.	33-24-59.7.	Coverage for the treatment of morbidly obese patients; short title; legislative findings; adoption of rules and regulations by Commissioner.
33-24-28.	Termination of coverage of dependent child upon attainment of specified age.	33-24-59.13.	Exemptions from certain unfair trade practices for certain wellness and health improvement programs; incentives.
33-24-45.	Cancellation or nonrenewal of automobile or motorcycle policies; procedure for review by Commissioner.	33-24-59.14.	(Effective January 1, 2013) Definitions; prompt pay requirements; penalties.
33-24-53.	Compensation for referrals or recommendations to attorneys prohibited; penalties.		
33-24-54.	Payments to nonparticipat-		

Sec.

33-24-59.15. Definitions; dental insurance.

Article 3

Breast Cancer Patient Care

33-24-72. Mastectomy; lymph node

dissection; coverage for inpatient care and follow-up visits required by health insurers; notice to policyholders.

RESEARCH REFERENCES

Am. Jur. Proof of Facts. — Insurer's Wrongful Refusal to Settle Within Policy Limits, 6 POF2d 247.

Insurer's Breach of Covenant of Good Faith and Fair Dealing — First Party Claims, 31 POF2d 323.

Civil Conspiracy to Deny First-Party Insurance Benefits, 49 POF2d 473.

Insurance Bad-Faith Actions — "Advice-of-Counsel" Defense, 16 POF3d 419.

Punitive Damages Against an Insurer for the Bad-Faith Handling of a First-Party Claim, 18 POF3d 323.

Insured's Proof That Pollution Exclusion Clause Does Not Bar Coverage for Environmental Claims, 38 POF3d 477.

Insurer's Failure to Investigate Claim in Good Faith, 46 POF3d 289.

Loss by Storm Damage Under Property Insurance, 49 POF3d 501.

ARTICLE 1

GENERAL PROVISIONS

33-24-1. Definitions.

JUDICIAL DECISIONS

Later-added vehicle part of original policy. — Because the insurance coverage for the vehicle the claimant was driving at the time of the accident was intended to be part of the original policy, did not constitute a new policy, and was simply added to the existing automobile coverage, the in-

surer was not required to notify the insured of the change in the law or to secure a separate uninsured motorist election at the time the vehicle was added to the policy. *Soufi v. Haygood*, 282 Ga. App. 593, 639 S.E.2d 395 (2006).

33-24-3. Insurable interest — Personal insurance.

(a) An insurable interest, with reference to personal insurance, is an interest based upon a reasonable expectation of pecuniary advantage through the continued life, health, or bodily safety of another person and consequent loss by reason of such person's death or disability or a substantial interest engendered by love and affection in the case of individuals closely related by blood or by law.

(b) An individual has an unlimited insurable interest in his or her own life, health, and bodily safety and may lawfully take out a policy of insurance on his or her own life, health, or bodily safety and have the

policy made payable to whomsoever such individual pleases, regardless of whether the beneficiary designated has an insurable interest.

(c) The trustee of a trust established by an individual settlor has an insurable interest in the life of that individual settlor and has the same insurable interest in the life of any other individual as does such individual settlor. The trustee of a trust has the same insurable interest in the life of any other individual as does any beneficiary of the trust with respect to proceeds of insurance on the life of such individual or any portion of such proceeds that are allocable to such beneficiary's interest in such trust. If multiple beneficiaries of a trust have an insurable interest in the life of the same individual, the trustee of such trust has the same aggregate insurable interest in such individual's life as such beneficiaries with respect to proceeds of insurance on the life of such individual or any portion of such proceeds that is allocable in the aggregate to such beneficiaries' interest in the trust.

(d) A corporation, foreign or domestic, has an insurable interest in the life of any individual:

(1) Holding at least 10 percent of the issued and outstanding shares of such corporation; or

(2) In whom the shareholders holding a majority of the issued and outstanding shares have an insurable interest, whether arising out of their status as shareholders of the corporation or otherwise,

and in the life or physical or mental ability of any of its directors, officers, or employees or the directors, officers, or employees of any of its subsidiaries or any other person whose death or physical or mental disability might cause financial loss to the corporation; or, pursuant to any contractual arrangement with any shareholder concerning the reacquisition of shares owned by him or her at the time of his or her death or disability, on the life or physical or mental ability of that shareholder for the purpose of carrying out such contractual arrangement; or, pursuant to any contract obligating the corporation as part of compensation arrangements or pursuant to a contract obligating the corporation as guarantor or surety, on the life of the principal obligor. The trustee of a trust established by a corporation for the sole benefit of the corporation has the same insurable interest in the life or physical or mental ability of any person as does the corporation. The trustee of a trust established by a corporation providing life, health, disability, retirement, or similar benefits to employees of the corporation or its affiliates and acting in a fiduciary capacity with respect to such employees, retired employees, or their dependents or beneficiaries has an insurable interest in the lives of employees for whom such benefits are to be provided. As used in this subsection, the term "employee" shall include any and all directors, officers, employees, or retired employees.

The term “employee” shall include any former employee, but only for the purpose of replacing existing life insurance that will be surrendered in exchange for new life insurance in an amount not exceeding the insurance being surrendered.

(e) The insurable interest of a corporation or trustee which has been established pursuant to subsection (d) of this Code section shall be conveyed automatically to another corporation or to the trustee of a trust established by such other corporation for its sole benefit which has acquired by purchase, merger, or otherwise all or part of the first corporation’s business. A corporation or the trustee of a trust established by such corporation for its sole benefit may exchange any policy of insurance issued to itself or to another corporation or the trustee of a trust established by such other corporation for its sole benefit from which the exchanging corporation has acquired by purchase, merger, or otherwise all or part of such other corporation’s business for a new policy of insurance issued to itself without establishing a new insurable interest at the time of such exchange.

(f) A shareholder in a corporation has an insurable interest in the life of any other shareholder pursuant to any contractual arrangement between or among such shareholders concerning the purchase by surviving shareholders of shares owned by a deceased or disabled shareholder, for the purpose of carrying out such contractual arrangement.

(g) A partnership, limited liability company, business trust, or other business entity established under the laws of any state or of the United States shall have the same insurable interests as a corporation, as set forth in subsections (d) and (e) of this Code section, including, without limitation, insurable interests in such entity’s partners, members, or holders of other equity ownership interests and in officers, directors, employees, and those of any subsidiaries of any such entity. The partners of a partnership, the owners of a limited liability company, and the owners of equity interests in any form of business entity have the same insurable interest in the lives of the other partners, members, or equity interest owners as do shareholders of corporations.

(h) An insurable interest must exist at the time the contract of personal insurance becomes effective but need not exist at the time the loss occurs.

(i) Any personal insurance contract procured or caused to be procured upon another individual is void unless the benefits under the contract are payable to the individual insured or such individual’s personal representative or to a person having, at the time when the contract was made, an insurable interest in the individual insured. In the case of a void contract, the insurer shall not be liable on the contract

but shall be liable to repay to the person or persons who have paid the premiums all premium payments without interest.

(j) A charitable institution as defined under Sections 501(c)(3), 501(c)(6), 501(c)(8), and 501(c)(9) of the Internal Revenue Code of 1986 shall have an insurable interest in the life of any donor.

(k) The insurable interests set forth in this Code section are not exclusive but are cumulative of and not in lieu of insurable interests existing in common law and not expressly set forth in this Code section. No part of this Code section specifically recognizing any insurable interest shall create any presumption or implication that such insurable interest did not exist prior to July 1, 2006. To the contrary, an insurable interest shall be presumed with respect to any life insurance policy issued prior to July 1, 2006, to any person whose insurable interest is recognized in this Code section. (Code 1933, § 56-2404, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1988, p. 317, § 1; Ga. L. 1989, p. 1109, § 1; Ga. L. 1991, p. 1123, §§ 1, 2; Ga. L. 1993, p. 1721, § 3; Ga. L. 1995, p. 776, § 2; Ga. L. 2003, p. 482, § 1; Ga. L. 2006, p. 869, § 1/ HB 1484.)

The 2006 amendment, effective July 1, 2006, inserted “or her” in the middle of subsection (b); added subsection (c); redesignated former subsections (c) and (c.1) as subsections (d) and (e), respectively; in subsection (d), added “in the life of any individual” at the end of the introductory paragraph, added paragraphs (d)(1) and (d)(2), and added “and” at the beginning of

the ending undesignated language; substituted “subsection (d)” for “subsection (c)” in the middle of the first sentence of subsection (e); added subsections (f) and (g); redesignated former subsections (d) through (f) as present subsections (h) through (j), respectively; and added subsection (k).

33-24-4. Insurable interest — Property insurance.

JUDICIAL DECISIONS

ANALYSIS

PARTIES WITH INSURABLE INTEREST

PARTIES WITHOUT INSURABLE INTEREST

Parties With Insurable Interest

Cargo carrier had insurable interest in cargo owned by third party. — Because it had liability to the owner of cargo for loss to the cargo during transportation under the Carmack Amendment to the Interstate Commerce Act, 49 U.S.C. § 14706(a)(1), a cargo carrier had an insurable interest in cargo it was transporting for an owner. *Certain Underwriters at Lloyds, London v. DTI Logistics, Inc.*, 300 Ga. App. 715, 686 S.E.2d 333 (2009).

Parties Without Insurable Interest

Individual failed to show an interest in a grantee corporation. — Individual who was a sole shareholder of a corporation did not have an insurable interest in property that was quitclaimed to a corporation, absent any showing that the individual had an interest in the grantee corporation or that the two corporations were the same. *Muhammad v. Allstate Ins. Co.*, 313 Ga. App. 531, 722 S.E.2d 136 (2012).

33-24-6. Consent of insured to insurance contract; exceptions; reliance by insurer on statements in application.

(a) No life or accident and sickness insurance contract upon an individual, except a contract of group life insurance or of group or blanket accident and sickness insurance, shall be made or effectuated unless at the time of the making of the contract the individual insured, being of competent legal capacity to contract, applies for a life or accident and sickness insurance contract or consents in writing to the contract, except in the following cases:

(1) A spouse may effectuate insurance upon the other spouse;

(2) Any person having an insurable interest in the life of a minor or any person upon whom a minor is dependent for support and maintenance may effectuate insurance upon the life of or pertaining to the minor;

(3) An application for a family policy may be signed by either parent, by a stepparent, or by husband or wife;

(4) A publicly owned corporation may effectuate insurance upon its employees in whom it has an insurable interest;

(5) A corporation not described in paragraph (4) of this subsection may effectuate insurance upon its employees in whom it has an insurable interest, and a trustee of a trust established by a corporation providing life, health, disability, retirement, or similar benefits may effectuate insurance upon employees for whom such benefits are to be provided if the insurance contract or contracts held by such corporation or trustee cover at least two employees. For purposes of this paragraph, any employee of a group of corporations consisting of a parent corporation and its directly or indirectly owned subsidiaries shall be considered to be an employee of each corporation within that group; or

(6) A corporation described in paragraph (4) or (5) of this subsection or the trustee of a trust established by such corporation for its sole benefit may exchange any policy which was issued to itself on the life of an employee or retiree of the corporation, or which was issued to another corporation or the trustee of a trust established by such other corporation for its sole benefit on the life of an employee or retiree of such other corporation, and the exchanging corporation has acquired by purchase, merger, or otherwise all or part of such other corporation's business for a new policy of insurance on such individual's life issued to the exchanging corporation.

(b)(1) If a contract of life insurance is issued as authorized in paragraph (4) or (5) of subsection (a) of this Code section, the insurer

shall be required to give written notice of such life insurance in accordance with paragraph (3) of this subsection and provide the employees an opportunity to refuse to participate. For all contracts of life insurance issued or delivered for issuance in this state after July 1, 2003, pursuant to paragraph (4) or (5) of subsection (a) of this Code section, the written consent of each individual proposed to be insured shall be obtained prior to the issuance of a policy on such individual. Written consent shall include an acknowledgment that the corporation may maintain life insurance coverage on such individual after such individual's employment with the corporation has terminated.

(2) If a contract of life insurance is issued as authorized in paragraphs (1) or (2) of subsection (a) of this Code section, the insurer shall be required to give written notice of such life insurance in accordance with paragraph (3) of this subsection.

(3) At the time of the issuance or delivery of the contract of insurance, notice of the issuance of the policy shall be delivered to the insured in person or by depositing the notice in the United States mail, to be dispatched by at least first-class mail to the home, business, or other address of record of the insured. The insurer may obtain a receipt provided by the United States Postal Service as evidence of mailing such notice or obtain such other evidence of mailing as prescribed or accepted by the United States Postal Service. The insurer shall not be required to provide the notice set forth in this subsection with respect to any application for credit life insurance; any insured who is older than the age of majority and who has signed or otherwise acknowledged the application in writing; any application for insurance covering the life of a minor; or any application for a contract of life insurance with a face amount of less than \$10,000.00.

(c) An insurer shall be entitled to rely upon all statements, declarations, and representations made by an applicant for insurance relative to the insurable interest which such applicant has in the insured; and no insurer shall incur any legal liability except as set forth in the policy, by virtue of any untrue statements, declarations, or representations so relied upon in good faith by the insurer.

(d) As used in paragraphs (4), (5), and (6) of subsection (a) of this Code section, the term "employee" shall include any and all directors, officers, employees, or retired employees. The term "employee" shall include any former employee, but only for the purpose of replacing existing life insurance that will be surrendered in exchange for new life insurance in an amount not exceeding the insurance being surrendered. (Code 1933, § 56-2407, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1987, p. 389, § 1; Ga. L. 1990, p. 132, § 1; Ga. L. 1990, p. 1000, § 1; Ga. L. 1993, p. 1721, § 4; Ga. L. 1995, p. 776, § 3; Ga. L. 2003, p. 482, § 2; Ga. L. 2009, p. 635, § 1/HB 80.)

The 2009 amendment, effective July 1, 2009, in paragraph (a)(5), in the first sentence, added a comma after “insurable interest”, deleted a comma following “provided”, substituted “such corporation or trustee” for “the corporation or the trustee”, and substituted “two employees” for “100 employees” and, at the end of the last sentence, substituted “that group” for “the group”.

33-24-6.1. Prerequisites for replacement life insurance exceeding insurance being surrendered.

Notwithstanding the provisions of subsection (d) of Code Section 33-24-3, subsection (d) of Code Section 33-24-6, or paragraph (11) of Code Section 33-27-3 which relate to the replacement of existing life insurance, any new life insurance may exceed the insurance being surrendered:

(1) When an entity has a proper interest pursuant to subsection (d) or (e) of Code Section 33-24-3 and the authority to effectuate life insurance pursuant to the provisions of paragraph (4), (5), or (6) of subsection (a) of Code Section 33-24-6; and

(2)(A) To the extent application of the cash surrender value from the old insurance as a premium under the new life insurance contract requires a larger amount of insurance to qualify as life insurance or to be not treated as a modified endowment contract for federal income tax purposes;

(B) To otherwise comply with applicable federal law; or

(C) When, upon cessation of premium payments, a former employee or trustee elects under the policy to use the cash value available under the policy to restructure the term, face amount, or investment options under the policy, even though such restructuring may result in an increase in the amount of the insurance. (Code 1981, § 33-24-6.1, enacted by Ga. L. 1997, p. 683, § 3; Ga. L. 2006, p. 869, § 2/HB 1484.)

The 2006 amendment, effective July 1, 2006, substituted “subsection (d)” for “subsection (c)” near the beginning of the introductory paragraph; and substituted “subsection (d) or (e)” for “subsection (c) or (c.1)” near the beginning of paragraph (1).

33-24-7. Statements and descriptions in applications or in negotiations deemed representations and not warranties; effect of misrepresentations upon recovery under policies.

Law reviews. — For annual survey of insurance law, see 56 Mercer L. Rev. 253 (2004). For survey article on insurance law, see 60 Mercer L. Rev. 191 (2008). For survey article on construction law, see 60 Mercer L. Rev. 59 (2008). For annual survey of law on insurance, see 62 Mercer L. Rev. 139 (2010).

JUDICIAL DECISIONS

ANALYSIS

GENERAL CONSIDERATION
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General Consideration

Immediate tender of premium not required for recession. — In a case involving O.C.G.A. § 33-24-7(b), a life insurance company did not waive its right to rescind the policy by waiting to refund the premium paid under the policy until eighteen months after it had received permission from the district court to interplead the premium. Immediate tender of a premium is not required by the law of Georgia in order to rescind a policy. *Am. Gen. Life Ins. Co. v. Schoenthal Family, LLC*, 555 F.3d 1331 (11th Cir. 2009).

Where there is a material misrepresentation, the policy may be voided.

In a breach of contract action filed by an insured against its insurer, the trial court did not err in granting the insurer summary judgment as to the issue of coverage, as questions answered untruthfully in the application for insurance by the insured amounted to misrepresentations warranting a cancellation of the policy at issue, pursuant to O.C.G.A. § 33-24-7. *T. J. Blake Trucking, Inc. v. Alea London, Ltd.*, 284 Ga. App. 384, 643 S.E.2d 762 (2007), cert. denied, 2007 Ga. LEXIS 505 (Ga. 2007).

Good faith irrelevant when misrepresenting material facts.

When insureds sued an insurer for breach of contract following the rescission of their insurance policy, it was proper to instruct that even a misrepresentation given in good faith would void the policy; under O.C.G.A. § 33-24-7(b)(2) and (3), an insurer did not have to show that a representation was fraudulent, only that it was material and false, and the “to the best of my knowledge and belief” language on the application meant only that the insureds were relying upon their own knowledge, not upon that of others such as an agent. *White v. Am. Family Life Assur. Co.*, 284 Ga. App. 58, 643 S.E.2d 298 (2007).

Summary judgment proper where insurer showed representation of

business was false. — Because an insurer carried its burden of showing that the representation of an insured’s business was false, and that the representation was material in that the representation changed the nature, extent, or character of the insurance coverage risk, the trial court did not err in granting the insurer summary judgment. *Marchant v. Travelers Indem. Co.*, 286 Ga. App. 370, 650 S.E.2d 316 (2007).

Cited in *C. Ingram Co. v. Phila. Indem. Ins. Co.*, 303 Ga. App. 548, 694 S.E.2d 181 (2010).

What is Material

Objective standard applied.

In a case involving O.C.G.A. § 33-24-7(b), the life insurance policy beneficiaries unsuccessfully argued that determining the materiality of the deceased’s misrepresentations required that the district court consider the actual conduct of the insurance company when the company approved the deceased’s life insurance policy. The test for materiality under O.C.G.A. § 33-24-7(b)(2) was the objective standard of conduct of a prudent insurer, not a subjective standard about the actual conduct of a particular insurance company. *Am. Gen. Life Ins. Co. v. Schoenthal Family, LLC*, 555 F.3d 1331 (11th Cir. 2009).

A material representation is one that would influence a prudent insurer, etc.

Insurer prevailed on a beneficiary’s breach of contract and bad faith claims because the insured made a material misrepresentation under O.C.G.A. § 33-24-7 by the failure to disclose a driving under the influence conviction within five years of the issuance of the life insurance policy and the insured would not have received the rating and premium offered by the insurer if the conviction had been disclosed. *Dracz v. Am. Gen. Life Ins. Co.*, 427 F. Supp. 2d 1165 (M.D. Ga. 2006).

Loss unconnected to misrepresentation.

As the evidence showed that an insurer would not have reinstated a homeowner's policy if the insurer knew the insureds planned to reinstall a diving board, the insureds, by providing a photo showing the board had been removed, made a material misrepresentation to the insurer. Under O.C.G.A. § 33-24-7(b), the fact that the insureds' subsequent loss was unrelated to the use of the diving board was irrelevant in determining that the insureds' misrepresentation as to board's permanent removal voided coverage. *Pope v. Mercury Indem. Co.*, 297 Ga. App. 535, 677 S.E.2d 693 (2009).

Cancer diagnosis and insurance application timeline. — To the extent defendant life insurance company claimed an insured's failure to disclose health problems was a material misrepresentation absolving the company of liability under O.C.G.A. § 33-24-7(b), the jury was to decide fault, and issues as to whether the insured learned the insured had cancer until after the insured was told the policy was approved precluded summary judgment against plaintiff, the trustee of a family trust, who sought proceeds of the life insurance policy that insured the life of the trustee's mother, the insured. *Nixon v. Lincoln Nat'l Ins. Co.*, 2005 U.S. App. LEXIS 7935 (11th Cir. May 5, 2005) (Unpublished).

Lack of material misrepresentation, incorrect statement, or omission. — Insurer improperly rescinded a directors and officers insurance policy with its insured because it failed to prove that the insured made any material misrepresentation, incorrect statement, or omission, either in the application or at the sole meeting between the insured and the insurer, sufficient to satisfy O.C.G.A. § 33-24-7 or Georgia common law governing fraudulent procurement. *Exec. Risk Indem. v. AFC Enters.*, 510 F. Supp. 2d 1308 (N.D. Ga. 2007), *aff'd*, 279 Fed. Appx. 793 (11th Cir. 2008).

Misrepresentation as to net worth and income. — If an insured's application drastically misrepresented the insured's net worth and income, and plaintiff insurer's expert testified no insurer

would have issued the \$7 million life insurance policy for estate planning purposes had the insurer known the insured's net worth was \$160,000 and income was \$7,200, rescission was proper under O.C.G.A. § 33-24-7(b)(2) and the insurer was granted summary judgment against defendants, the participants in the "estate planning" insurance program covering the deceased elderly insured. *Am. Gen. Life Ins. Co. v. Schoenthal Family, L.L.C.*, 248 F.R.D. 298 (N.D. Ga. 2008), *aff'd*, 555 F.3d 1331 (11th Cir. 2009).

In a case involving O.C.G.A. § 33-24-7(b), the beneficiaries argued unsuccessfully that the life insurance company denied the claim in bad faith. The deceased's objectively material misrepresentations in the deceased's application as to the deceased's income and net worth constituted a reasonable ground for the insurance company to contest the claim, and bad faith claims failed as a matter of law if the insurer had any reasonable ground to contest the claim. *Am. Gen. Life Ins. Co. v. Schoenthal Family, LLC*, 555 F.3d 1331 (11th Cir. 2009).

Misrepresentation as to existence of circumstances that could reasonably give rise to professional liability claim. — Defendant attorney's numerous and substantial payments to a credit card from the real estate closing trust account of the other defendant, the attorney's law firm, allowed plaintiff insurer to rescind its professional liability policy under O.C.G.A. § 33-24-7(b)(2) because the attorney had stated in the insurance application that the attorney knew of no circumstance that could reasonably give rise to a professional liability claim. *Medmarc Cas. Ins. Co. v. Reagan Law Group, P.C.*, 525 F. Supp. 2d 1334 (N.D. Ga. 2007).

Expert's opinion refused.

Based upon an insured's material misrepresentation in the insurance application, an insurer may retrospectively void a commercial insurance policy that includes motor vehicle liability coverage as long as the cancellation of the policy does not leave an injured third party without available liability insurance in an amount equal to the minimum statutory requirements. *FCCI Ins. Group v. Rodgers Metal Craft, Inc.*, No. 4:06-CV-107 (CDL), 2008

U.S. Dist. LEXIS 57649 (M.D. Ga. July 28, 2008).

Expert testimony admitted. — In a case involving O.C.G.A. § 33-24-7(b), the life insurance policy beneficiaries unsuccessfully argued that the insurance company's expert's testimony was unreliable because experience alone could never form the basis for expert testimony. The district court did not abuse the court's discretion when the court determined that the expert's education and experience qualified the expert to testify as an expert about insurance industry standards since the expert had ample knowledge and experience about the subject; *inter alia*, the expert had obtained masters and doctoral degrees in risk management and insurance, the expert had taught classes in risk management and insurance, including underwriting in general and financial underwriting in particular at the college level, and the expert had coauthored a

leading college-level textbook on life insurance that included chapters on financial underwriting. *Am. Gen. Life Ins. Co. v. Schoenthal Family, LLC*, 555 F.3d 1331 (11th Cir. 2009).

Procedure

Rescission under paragraph (b)(3) of O.C.G.A. § 33-24-7(b)(3) was inappropriate in an action against defendants, the participants in an "estate planning" insurance program covering the deceased elderly insured, because one of plaintiff insurer's experts used contradictory underwriting standards regarding testimony that the policy would not have been issued if the truth regarding the insured's financial condition had been known. *Am. Gen. Life Ins. Co. v. Schoenthal Family, L.L.C.*, 248 F.R.D. 298 (N.D. Ga. 2008), *aff'd*, 555 F.3d 1331 (11th Cir. 2009).

RESEARCH REFERENCES

ALR. — Rescission of directors' and officers' liability insurance policy, 29 ALR6th 189.

33-24-14. Delivery of policies.

JUDICIAL DECISIONS

Where the insured had prior knowledge, etc.

Motorist's vehicle from the parent's insurance policy was properly relied on by an insurer in its denial of coverage of a driver, arising from a motor vehicle collision with the motorist, although the insurer failed to prove that it provided the parent with a written copy of the endorsement within a reasonable period of time of

the issuance thereof, as required by O.C.G.A. § 33-24-14, as the parent had notice of the endorsement because the motorist made the request to change the policy coverage; the decrease in premium was consideration for deletion of the coverage. *Danforth v. Gov't Emples. Ins. Co.*, 282 Ga. App. 421, 638 S.E.2d 852 (2006), cert. denied, 2007 Ga. LEXIS 143 (Ga. 2007).

33-24-16. Construction of policies.

JUDICIAL DECISIONS

ANALYSIS

GENERAL CONSIDERATIONS

General Considerations

Court's role in interpreting pollution policy exclusion. — In an action brought by a lessor against a former lessee, a dry cleaning corporation, for indemnification for remediation expenses incurred in cleaning up the contaminated shopping center property vacated by the lessee, the trial court properly refused to examine a Pollution Liability Exclusion Endorsement in a vacuum and, rather, considered that language in concert with other policy language addressing coverage of property damage arising out of the discharge of pollutants and thereby found that an umbrella policy provided coverage for quick, abrupt, and accidental dis-

charges of pollutants. The trial court properly determined that the inconsistent language of the Pollution Liability Exclusion and an Amendatory Endorsement were ambiguous as the Amendatory Endorsement narrowed the scope of Pollution Liability Exclusion by exempting from it discharges that were quick, abrupt, and accidental; but the Pollution Liability Exclusion Endorsement broadened the scope of Exclusion by extending the exclusion to any discharge. *State Farm Fire & Cas. Co. v. Walnut Ave. Partners, LLC*, 296 Ga. App. 648, 675 S.E.2d 534 (2009).

Cited in *Gentry Mach. Works, Inc. v. Harleysville Mut. Ins. Co.*, 621 F. Supp. 2d 1288 (M.D. Ga. 2008).

33-24-16.1. Clarification of term “actual charge” or “actual fee”.

(a) The term “actual charge” or “actual fee,” when used in an individual or group specified disease insurance policy, shall mean the amount actually paid by or on behalf of an insured person and accepted as full payment by a health care provider or other designated person for the goods or services provided.

(b) The General Assembly finds and declares that the provisions of subsection (a) of this Code section are intended to clarify the current correct interpretation of the defined terms for instances in which the particular insurance policy does not otherwise contain a definition. (Code 1981, § 33-24-16.1, enacted by Ga. L. 2006, p. 767, § 2/SB 385.)

Effective date. — This Code section became effective May 3, 2006.

33-24-17. Assignment of policies.

JUDICIAL DECISIONS

Nonassignment clause did not prevent assignment that did not change insurer's risk. — Because an insurance broker paid normal premiums on behalf of the insured in anticipation of a refund, and the insured promised that the refund would be paid directly to the broker despite language in the insurance contracts that refunds would be paid to the insured and despite a non-assignment clause, the

insured validly assigned its right to a refund to the broker; the non-assignment clause was permissible under O.C.G.A. § 33-24-17, but the court would not apply the clause to preclude the assignment because the assignment did not increase the insurer's risk. *Watson Ins. Agency, Inc. v. Chipman-Union, Inc.* (In re Chipman-Union, Inc.), 330 B.R. 851 (Bankr. M.D. Ga. 2005).

33-24-18. Contents of insurance policies and annuity contracts generally.

RESEARCH REFERENCES

Am. Jur. Proof of Facts. — Avoiding the “Business Pursuits” Exclusion — Insured’s Activity as Not Business Pursuit, 15 POF3d 515.

Avoiding the “Business Pursuits” Exclusion — Insured’s Activity as Ordinarily Incident to Nonbusiness Pursuits, 16 POF3d 355.

33-24-19.1. Certificate of insurance forms to be approved by Commissioner; definitions; required provisions of certificate.

(a) As used in this Code section, the term:

(1) “Certificate” or “certificate of insurance” means any document or instrument, no matter how titled or described, which is prepared or issued by an insurer or insurance producer as evidence of property or casualty insurance coverage. “Certificate” or “certificate of insurance” shall not include a policy of insurance or insurance binder, including any policy of insurance which may be referred to as a certificate, or any insurance information card or identification card issued in conjunction with a motor vehicle insurance policy.

(2) “Certificate holder” means any person, other than a policyholder, that requests, obtains, or possesses a certificate of insurance.

(3) “Insurance producer” means a person required to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

(4) “Insurer” means any person engaged as indemnitor, surety, or contractor who issues insurance as defined by Code Sections 33-7-3 and 33-7-6. Nothing in this Code section shall apply to or affect any offering of accident, sickness, or disability insurance by a fraternal benefit society, as provided under Code Section 33-15-60; nonprofit medical service corporations, as provided under Chapters 18 and 19 of this title; health care plans, as provided under Chapter 20 of this title; health maintenance organizations, as provided under Chapter 21 of this title; any provisions of accident and sickness insurance policies generally, as provided under Code Sections 33-24-20 through 33-24-31; individual accident and sickness insurance, as provided under Chapter 29 of this title; or group or blanket accident and sickness insurance, as provided under Chapter 30 of this title.

(5) “Person” means any individual, partnership, corporation, association, or other legal entity, including any government or governmental subdivision or agency.

(6) “Policyholder” means a person who has contracted with a property or casualty insurer for insurance coverage.

(b) No person, wherever located, may prepare, issue, or request the issuance of a certificate of insurance unless the form has been filed with and approved by the Commissioner of Insurance. No person, wherever located, may alter or modify an approved certificate of insurance form.

(c) The Commissioner of Insurance shall disapprove a form filed under this Code section, or withdraw approval of a form, if the form:

(1) Is unjust, unfair, misleading, or deceptive, or violates public policy;

(2) Fails to comply with the requirements of subsection (d) of this Code section; or

(3) Violates any law, including any regulation adopted by the Commissioner of Insurance.

(d) Each certificate of insurance must contain the following or similar statement: "This certificate of insurance is issued as a matter of information only and confers no rights upon the certificate holder. This certificate does not amend, extend, or alter the coverage, terms, exclusions, and conditions afforded by the policies referenced herein." However, the Commissioner of Insurance may approve a form filed under this Code section that does not state that the form is provided for information purposes only, if such form contains the following or similar statement: "This certificate of insurance does not amend, extend, or alter the coverage, terms, exclusions, and conditions afforded by the policies referenced herein."

(e) Standard certificate of insurance forms promulgated by the Association for Cooperative Operations Research and Development or the Insurance Services Office are deemed approved by the Commissioner of Insurance and are not required to be filed if the forms otherwise comply with the requirements of this Code section.

(f) No person, wherever located, shall demand or request the issuance of a certificate of insurance from an insurer, insurance producer, or policyholder that contains any false or misleading information concerning the policy of insurance to which the certificate makes reference.

(g) No person, wherever located, may knowingly prepare or issue a certificate of insurance that contains any false or misleading information or that purports to affirmatively or negatively alter, amend, or extend the coverage provided by the policy of insurance to which the certificate makes reference.

(h) No person may prepare, issue, or request, either in addition to or in lieu of a certificate of insurance, an opinion letter or other document or correspondence that is inconsistent with this Code section.

(i) The provisions of this Code section shall apply to all certificate holders, policyholders, insurers, insurance producers, and certificate of

insurance forms issued as evidence of insurance coverages on property, operations, or risks located in this state, regardless of where the certificate holder, policyholder, insurer, or insurance producer is located.

(j) A certificate of insurance is not a policy of insurance and does not affirmatively or negatively amend, extend, or alter the coverage afforded by the policy to which the certificate of insurance makes reference. A certificate of insurance shall not confer to a certificate holder new or additional rights beyond what the referenced policy of insurance expressly provides.

(k) No certificate of insurance shall contain references to contracts, including construction or service contracts, other than the referenced contract of insurance. Notwithstanding any requirement, term, or condition of any contract or other document with respect to which a certificate of insurance may be issued or may pertain, the insurance afforded by the referenced policy of insurance is subject to all the terms, exclusions, and conditions of the policy itself.

(l) A certificate holder shall have a legal right to notice of cancellation, nonrenewal, or any material change, or any similar notice concerning a policy of insurance only if the person is named within the policy or any endorsement and the policy or endorsement requires notice to be provided. The terms and conditions of the notice, including the required timing of the notice, are governed by the policy of insurance and cannot be altered by a certificate of insurance.

(m) Any certificate of insurance or any other document or correspondence prepared, issued, or requested in violation of this Code section shall be null and void and of no force and effect.

(n) Any person who violates this Code section may be fined up to \$5,000.00 per violation.

(o) The Commissioner of Insurance shall have the power to examine and investigate the activities of any person that the Commissioner reasonably believes has been or is engaged in an act or practice prohibited by this Code section. The Commissioner of Insurance shall have the power to enforce the provisions of this Code section and to impose any authorized penalty or remedy against any person who violates this Code section.

(p) The Commissioner of Insurance may adopt reasonable rules and regulations as are necessary or proper to carry out the provisions of this Code section. (Code 1981, § 33-24-19.1, enacted by Ga. L. 2011, p. 434, § 1/HB 66.)

Effective date. — This Code section became effective July 1, 2011.

33-24-21.1. Group accident and sickness contracts; conversion privilege and continuation right provisions.

(a) As used in this Code section, the term:

(1) “Assistance eligible individual” shall have the same meaning as provided by Section 3001 of Title III of the federal American Recovery and Reinvestment Act of 2009, as amended.

(2) “Creditable coverage” under another health benefit plan means medical expense coverage with no greater than a 90 day gap in coverage under any of the following:

(A) Medicare or Medicaid;

(B) An employer based accident and sickness insurance or health benefit arrangement;

(C) An individual accident and sickness insurance policy, including coverage issued by a health maintenance organization, non-profit hospital or nonprofit medical service corporation, health care corporation, or fraternal benefit society;

(D) A spouse’s benefits or coverage under medicare or Medicaid or an employer based health insurance or health benefit arrangement;

(E) A conversion policy;

(F) A franchise policy issued on an individual basis to a member of a true association as defined in subsection (b) of Code Section 33-30-1;

(G) A health plan formed pursuant to 10 U.S.C. Chapter 55;

(H) A health plan provided through the Indian Health Service or a tribal organization program or both;

(I) A state health benefits risk pool;

(J) A health plan formed pursuant to 5 U.S.C. Chapter 89;

(K) A public health plan; or

(L) A Peace Corps Act health benefit plan.

(3) “Eligible dependent” means a person who is entitled to medical benefits coverage under a group contract or group plan by reason of such person’s dependency on or relationship to a group member.

(4) “Group contract or group plan” is synonymous with the term “contract or plan” and means:

(A) A group contract of the type issued by a nonprofit medical service corporation established under Chapter 18 of this title;

(B) A group contract of the type issued by a nonprofit hospital service corporation established under Chapter 19 of this title;

(C) A group contract of the type issued by a health care plan established under Chapter 20 of this title;

(D) A group contract of the type issued by a health maintenance organization established under Chapter 21 of this title; or

(E) A group accident and sickness insurance policy or contract, as defined in Chapter 30 of this title.

(5) "Group member" means a person who has been a member of the group for at least six months and who is entitled to medical benefits coverage under a group contract or group plan and who is an insured, certificate holder, or subscriber under the contract or plan.

(6) "Insurer" means an insurance company, health care corporation, nonprofit hospital service corporation, medical service nonprofit corporation, health care plan, or health maintenance organization.

(7) "Qualifying eligible individual" means:

(A) A Georgia domiciliary, for whom, as of the date on which the individual seeks coverage under this Code section, the aggregate of the periods of creditable coverage is 18 months or more; and

(B) Who is not eligible for coverage under any of the following:

(i) A group health plan, including continuation rights under this Code section or the federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA);

(ii) Part A or Part B of Title XVIII of the federal Social Security Act; or

(iii) The state plan under Title XIX of the federal Social Security Act or any successor program.

(a.1) Any group member or qualifying eligible individual who is an assistance eligible individual as provided by Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended, during the period permitted under such act whose coverage has been terminated and who has been continuously covered under the group contract or group plan, and under any contract or plan providing similar benefits that it replaces, for at least six months immediately prior to such termination, shall be entitled to have his or her coverage and the coverage of his or her eligible dependents continued under the contract or plan in accordance with paragraph (2) of subsection (c) of this Code section. Such coverage shall continue for the fractional policy month remaining, if any, at termination plus up to the maximum number of additional policy months specified in paragraph (2) of

subsection (c) of this Code section upon payment of the premium to the insurer by cash, certified check, or money order, at the same rate for active group members set forth in the contract or plan, on a monthly basis in advance as such premium becomes due during this coverage period. An assistance eligible individual who is in a transition period as defined in Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended, shall be treated for purposes of any continuation of coverage provision as having timely paid such premium if such individual was covered under the continuation of coverage to which such premium relates for the period immediately preceding such transition period, if such individual remains eligible for such continuation of coverage, and if such individual pays the amount of such premium not later than 30 days after the date of provision of notice regarding eligibility for extended continuation of coverage. For the period that the assistance eligible individual is eligible for the premium reduction assistance as provided in Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended, such premium payment shall be calculated as 35 percent of the rate for active group members including any portion of the premium paid by a former employer or other person if such employer or other person no longer contributes premium payments for this coverage.

(a.2) The rights and benefits under this Code section attributable to Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended, shall expire when that act expires. Any extension of such benefits shall require an Act of the Georgia General Assembly. Under no circumstances shall the extended benefits for assistance eligible individuals become the responsibility of the State of Georgia or any insurer after the expiration of the premium subsidy made available to individuals pursuant to Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended.

(b) Each group contract or group plan delivered or issued for delivery in this state, other than a group accident and sickness insurance policy, contract, or plan issued in connection with an extension of credit, which provides hospital, surgical, or major medical coverage, or any combination of these coverages, on an expense incurred or service basis, excluding contracts and plans which provide benefits for specific diseases or accidental injuries only, shall provide that members and qualifying eligible individuals whose insurance under the group contract or plan would otherwise terminate shall be entitled to continue their hospital, surgical, and major medical insurance coverage under that group contract or plan for themselves and their eligible dependents.

(c)(1) Any group member or qualifying eligible individual whose coverage has been terminated and who has been continuously cov-

ered under the group contract or group plan, and under any contract or plan providing similar benefits which it replaces, for at least six months immediately prior to such termination, shall be entitled to have his or her coverage and the coverage of his or her eligible dependents continued under the contract or plan. Such coverage must continue for the fractional policy month remaining, if any, at termination plus three additional policy months, upon payment of the premium by cash, certified check, or money order, at the option of the employer, to the policyholder or employer, at the same rate for active group members set forth in the contract or plan, on a monthly basis in advance as such premium becomes due during this coverage period. Such premium payment must include any portion of the premium paid by a former employer or other person if such employer or other person no longer contributes premium payments for this coverage. At the end of such period, the group member shall have the same conversion rights that were available on the date of termination of coverage in accordance with the conversion privileges contained in the group contract or group plan.

(2) Any group member or qualifying eligible individual who is an assistance eligible individual has a right to elect continuation of his or her coverage and the coverage of his or her dependents at any time between May 5, 2009, and 60 days after receiving notice from the employer's insurer of the right to participate in state continuation benefits under this Code section in accordance with Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended, if:

(A) The individual was involuntarily terminated from employment or otherwise experienced a loss of coverage due to qualifying events specified in Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended;

(B) The individual was eligible for state continuation under this chapter at the time of termination;

(C) The individual continues to be eligible for state continuation benefits under this chapter, provided that the total period of continuous eligibility shall not exceed the number of policy months equal to the maximum premium reduction period specified in Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended, as measured from the month of the qualifying event making the individual an assistance eligible individual; and

(D) The individual or the employer of the individual contacts the insurer and informs the insurer that the individual wants to take advantage of state continuation coverage under the provisions of

Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended.

(3) In addition to the group policy under which the group member was insured, the group member and any qualifying eligible individual shall, to the extent that such plan is currently offered under the group plans offered by the company, also be offered the option of continuation coverage through a high deductible health plan, or its actuarial equivalent, that is eligible for use with a health savings account under the applicable provisions of Section 223 of the Internal Revenue Code. Such high deductible health plans shall have premiums consistent with the underlying group plan of coverage rated relative to the standard or manual rates for the benefits provided.

(d)(1) A group member shall not be entitled to have coverage continued if: (A) termination of coverage occurred because the employment of the group member was terminated for cause; (B) termination of coverage occurred because the group member failed to pay any required contribution; or (C) any discontinued group coverage is immediately replaced by similar group coverage including coverage under a health benefits plan as defined in the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq. Further, a group member shall not be entitled to have coverage continued if the group contract or group plan was terminated in its entirety or was terminated with respect to a class to which the group member belonged. This subsection shall not affect conversion rights available to a qualifying eligible individual under any contract or plan.

(2) A qualifying eligible individual shall not be entitled to have coverage continued if the most recent creditable coverage within the coverage period was terminated based on one of the following factors: (A) failure of the qualifying eligible individual to pay premiums or contributions in accordance with the terms of the health insurance coverage or failure of the issuer to receive timely premium payments; (B) the qualifying eligible individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of coverage; or (C) any discontinued group coverage is immediately replaced by similar group coverage including coverage under a health benefits plan as defined in the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq. This subsection shall not affect conversion rights available to a group member under any contract or plan.

(e) If the group contract or group plan terminates while any group member or qualifying eligible individual is covered or whose coverage is being continued, the group administrator, as prescribed by the insurer, must notify each such group member or qualifying eligible individual that he or she must exercise his or her conversion rights within:

(1) Thirty days of such notice for group members who are not qualifying eligible individuals; or

(2) Sixty-three days of such notice for qualifying eligible individuals.

(f) Every group contract or group plan, other than a group accident and sickness insurance policy, contract, or plan issued in connection with an extension of credit, which provides hospital, surgical, or major medical expense insurance, or any combination of these coverages, on an expense incurred or service basis, excluding policies which provide benefits for specific diseases or for accidental injuries only, shall contain a conversion privilege provision.

(g) Eligibility for the converted policies or contracts shall be as follows:

(1) Any qualifying eligible individual whose insurance and its corresponding eligibility under the group policy, including any continuation available, elected, and exhausted under this Code section or the federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), has been terminated for any reason, including failure of the employer to pay premiums to the insurer, other than fraud or failure of the qualifying eligible individual to pay a required premium contribution to the employer or, if so required, to the insurer directly and who has at least 18 months of creditable coverage immediately prior to termination shall be entitled, without evidence of insurability, to convert to individual or group based coverage covering such qualifying eligible individual and any eligible dependents who were covered under the qualifying eligible individual's coverage under the group contract or group plan. Such conversion coverage must be, at the option of the individual, retroactive to the date of termination of the group coverage or the date on which continuation or COBRA coverage ended, whichever is later. The insurer must offer qualifying eligible individuals at least two distinct conversion options from which to choose. One such choice of coverage shall be comparable to comprehensive health insurance coverage offered in the individual market in this state or comparable to a standard option of coverage available under the group or individual health insurance laws of this state. The other choice may be more limited in nature but must also qualify as creditable coverage. Each coverage shall be filed, together with applicable rates, for approval by the Commissioner. Such choices shall be known as the "Enhanced Conversion Options";

(2) Premiums for the enhanced conversion options for all qualifying eligible individuals shall be determined in accordance with the following provisions:

(A) Solely for purposes of this subsection, the claims experience produced by all groups covered under comprehensive major medi-

cal or hospitalization accident and sickness insurance for each insurer shall be fully pooled to determine the group pool rate. Except to the extent that the claims experience of an individual group affects the overall experience of the group pool, the claims experience produced by any individual group of each insurer shall not be used in any manner for enhanced conversion policy rating purposes;

(B) Each insurer's group pool shall consist of each insurer's total claims experience produced by all groups in this state, regardless of the marketing mechanism or distribution system utilized in the sale of the group insurance from which the qualifying eligible individual is converting. The pool shall include the experience generated under any medical expense insurance coverage offered under separate group contracts and contracts issued to trusts, multiple employer trusts, or association groups or trusts, including trusts or arrangements providing group or group-type coverage issued to a trust or association or to any other group policyholder where such group or group-type contract provides coverage, primarily or incidentally, through contracts issued or issued for delivery in this state or provided by solicitation and sale to Georgia residents through an out-of-state multiple employer trust or arrangement; and any other group-type coverage which is determined to be a group shall also be included in the pool for enhanced conversion policy rating purposes; and

(C) Any other factors deemed relevant by the Commissioner may be considered in determination of each enhanced conversion policy pool rate so long as it does not have the effect of lessening the risk-spreading characteristic of the pooling requirement. Duration since issue and tier factors may not be considered in conversion policy rating. Notwithstanding subparagraph (A) of this paragraph, the total premium calculated for all enhanced conversion policies may deviate from the group pool rate by not more than plus or minus 50 percent based upon the experience generated under the pool of enhanced conversion policies so long as rates do not deviate for similarly situated individuals covered through the pool of enhanced conversion policies;

(3) Any group member who is not a qualifying eligible individual and whose insurance under the group policy has been terminated for any reason, including failure of the employer to pay premiums to the insurer, other than eligibility for medicare (reaching a limiting age for coverage under the group policy) or failure of the group member to pay a required premium contribution, and who has been continuously covered under the group contract or group plan, and under any contract or plan providing similar benefits which it replaces, for at

least six months immediately prior to termination shall be entitled, without evidence of insurability, to convert to individual or group coverage covering such group member and any eligible dependents who were covered under the group member's coverage under the group contract or group plan. Such conversion coverage must be, at the option of the individual, retroactive to the date of termination of the group coverage or the date on which continuation or COBRA coverage ended, whichever is later. The premium of the basic converted policy shall be determined in accordance with the insurer's table of premium rates applicable to the age and classification of risks of each person to be covered under that policy and to the type and amount of coverage provided. This form of conversion coverage shall be known as the "Basic Conversion Option"; and

(4) Nothing in this Code section shall be construed to prevent an insurer from offering additional options to qualifying eligible individuals or group members.

(h) Each group certificate issued to each group member or qualifying eligible individual, in addition to setting forth any conversion rights, shall set forth the continuation right in a separate provision bearing its own caption. The provisions shall clearly set forth a full description of the continuation and conversion rights available, including all requirements, limitations, and exceptions, the premium required, and the time of payment of all premiums due during the period of continuation or conversion.

(i) This Code section shall not apply to limited benefit insurance policies. For the purposes of this Code section, the term "limited benefit insurance" means accident and sickness insurance designed, advertised, and marketed to supplement major medical insurance. The term limited benefit insurance includes accident only, CHAMPUS supplement, dental, disability income, fixed indemnity, long-term care, medicare supplement, specified disease, vision, and any other accident and sickness insurance other than basic hospital expense, basic medical-surgical expense, and comprehensive major medical insurance coverage.

(j) The Commissioner shall adopt such rules and regulations as he or she deems necessary for the administration of this Code section. Such rules and regulations may prescribe various conversion plans, including minimum conversion standards and minimum benefits, but not requiring benefits in excess of those provided under the group contract or group plan from which conversion is made, scope of coverage, preexisting limitations, optional coverages, reductions, notices to covered persons, and such other requirements as the Commissioner deems necessary for the protection of the citizens of this state.

(k)(1) Except as provided in paragraph (2) of this subsection, this Code section shall apply to all group plans and group contracts

delivered or issued for delivery in this state on or after July 1, 2009, and to group plans and group contracts then in effect on the first anniversary date occurring on or after July 1, 2009.

(2) The provisions of paragraphs (1), (2), and (3) of subsection (c) of this Code section shall apply to all group plans and group contracts in effect on September 1, 2008.

(l) As soon as practicable, but no later than June 4, 2009, the Commissioner shall develop and direct insurers to issue notices for assistance eligible individuals regarding availability of expanded eligibility and continuation coverage assistance to be sent to the last known addresses of such assistance eligible individuals.

(m) Nothing in this chapter shall imply that individuals entitled to continuation coverage who are not assistance eligible individuals shall receive benefits beyond the period of coverage provided in paragraph (1) of subsection (c) of this Code section or that assistance eligible individuals are entitled to any continuation benefit period beyond what is provided by Section 3001 of Title III of the federal American Recovery and Reinvestment Act of 2009 or extensions to that Act which are enacted on and after May 5, 2009. (Code 1981, § 33-24-21.1, enacted by Ga. L. 1986, p. 688, § 1; Ga. L. 1990, p. 8, § 33; Ga. L. 1997, p. 1462, § 3; Ga. L. 1998, p. 1064, § 4; Ga. L. 2002, p. 441, § 10; Ga. L. 2009, p. 737, § 1/SB 94; Ga. L. 2010, p. 87, § 1/HB 1268; Ga. L. 2011, p. 752, § 33/HB 142.)

The 2009 amendment, effective May 5, 2009, in subsection (a), added paragraph (a)(1) and redesignated former paragraphs (a)(1) through (a)(6) as present paragraphs (a)(2) through (a)(7), respectively; added subsections (a.1) and (a.2); in subsection (c), designated the existing provisions as paragraph (c)(1), added the exception in the second sentence of paragraph (c)(1), and added paragraphs (c)(2) through (c)(4); in subsection (k), designated the existing provisions as paragraph (k)(1), in paragraph (k)(1), substituted "Except as provided in paragraph (2) of this subsection, this" for "This" and substituted "July 1, 2009" for "July 1, 1998" twice, and added paragraph (k)(2); and added subsections (l) and (m).

The 2010 amendment, effective May 20, 2010, in paragraph (a)(1), added "as amended" at the end; in subsection (a.1), in the first sentence, inserted "as amended" near the beginning and added "in accordance with paragraph (2) of subsection (c) of this Code section" at the end;

in the second sentence substituted "up to the maximum number of additional policy months specified in paragraph (2) of subsection (c) of this Code section" for "nine additional policy months"; added the third sentence, and, in the fourth sentence, substituted "reduction assistance" for "assistance subsidy" and inserted "as amended"; in subsection (a.2), inserted "as amended," in the first sentence, and substituted "the expiration of the premium subsidy made available to individuals pursuant to Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended" for "September 30, 2010" at the end of the second sentence; in paragraph (c)(1), deleted "except the period of continuation coverage for assistance eligible individual in subsection (a.1) of this Code section, shall be nine months" near the middle; in paragraph (c)(2), in the introductory paragraph, substituted "Any group member or qualifying eligible individual" for "A covered individual" at the beginning, deleted

“a second election period for” near the middle, and inserted “, as amended,” near the end; in subparagraph (c)(2)(A), substituted “or otherwise experienced a loss of coverage due to qualifying events specified” for “between September 1, 2008, and February 17, 2009, as defined” and added “, as amended” at the end; in subparagraph (c)(2)(C), substituted “the number of” for “nine”, inserted “equal to the maximum premium reduction period specified in Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended, as measured” following “policy months”, and deleted “or the date of the election as provided in this paragraph, whichever is later” near the end; in subparagraph (c)(2)(D), deleted “the second election period for” preceding “state” and added “, as amended” at the end; deleted paragraph (c)(4), which read: “Claims for a covered individual under continuation of coverage shall not be considered in rating or rerating the group premiums for the group from which the continuation of coverage is provided, except that the pooled experience for all of

the insurer’s continuation of coverage claims for fully insured claims may impact all such groups on an equal percentage basis.”; in paragraph (k)(2), substituted “paragraphs (1), (2), and (3)” for “paragraphs (2) and (3)” near the beginning; in subsection (l), deleted “second election,” following “eligibility,”; and added “or extensions to that Act which are enacted on and after May 5, 2009” at the end of subsection (m).

The 2011 amendment, effective May 13, 2011, part of an Act to revise, modernize, and correct the Code, revised punctuation in subsection (l).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2009, in paragraph (c)(2), “May 5, 2009,” was substituted for “the effective date of this paragraph”, and in subsection (l), “June 4, 2009” was substituted for “30 days after the effective date of this subsection”.

Pursuant to Code Section 28-9-5, in 2010, an extra comma was deleted following “months” in the second sentence of paragraph (c)(1).

33-24-28. Termination of coverage of dependent child upon attainment of specified age.

(a) An individual hospital or medical expense insurance policy or hospital or medical service plan contract which provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the policy or contract shall also provide in substance that attainment of the limiting age shall not operate to terminate the coverage of the child while the child is and continues to be both incapable of self-sustaining employment by reason of developmental disability or physical disability as determined by the Department of Behavioral Health and Developmental Disabilities and chiefly dependent upon the policyholder or subscriber for support and maintenance, provided proof of incapacity and dependency is furnished to the insurer, hospital, or medical service plan corporation by the policyholder or subscriber within 31 days of the child’s attainment of the limiting age and subsequently as may be required by the insurer or corporation but not more frequently than annually after the two-year period following the child’s attainment of the limiting age.

(b) A group hospital or medical expense insurance policy or hospital or medical service plan contract which provides that coverage of a dependent child of an employee or other member of the covered group shall terminate upon attainment of the limiting age for dependent

children specified in the policy or contract shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of the child while the child is and continues to be both incapable of self-sustaining employment by reason of developmental disability or physical disability as determined by the Department of Behavioral Health and Developmental Disabilities and chiefly dependent upon the employee or member for support and maintenance, provided proof of incapacity and dependency is furnished to the insurer or hospital or medical service plan corporation by the employee or member within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer or corporation but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

(c) This Code section shall apply equally to health insurance policies issued pursuant to Chapters 29 and 30 of this title, contracts issued by nonprofit hospital and medical service corporations under Chapters 18 and 19 of this title, coverage by health maintenance organizations under Chapter 21 of this title, and health care plans under Chapter 20 of this title. (Code 1933, § 56-2440, enacted by Ga. L. 1972, p. 1156, § 1; Ga. L. 1995, p. 1302, § 13; Ga. L. 2009, p. 453, §§ 3-2, 3-6/HB 228.)

The 2009 amendment, effective July 1, 2009, substituted “developmental disability” for “mental retardation” and substituted “Department of Behavioral

Health and Developmental Disabilities” for “Department of Human Resources” in subsections (a) and (b).

33-24-28.1. Coverage of treatment of mental disorders.

Law reviews. — For note, “The Parity Cure: Solving Unequal Treatment of Mental Illness Health Insurance Through Fed-

eral Legislation,” see 44 Ga. L. Rev. 511 (2010).

33-24-29. Coverage for treatment of mental disorders under accident and sickness insurance benefit plans providing major medical benefits covering small groups; federal law.

Law reviews. — For note, “The Parity Cure: Solving Unequal Treatment of Mental Illness Health Insurance Through Fed-

eral Legislation,” see 44 Ga. L. Rev. 511 (2010).

33-24-33. Binders and other contracts for temporary insurance.

JUDICIAL DECISIONS

Binder contained no ambiguity. — Carrier properly applied a coinsurance penalty clause and refused to pay plaintiff

insured's claim for damaged tanks and buildings in full because neither the insurance binder, pursuant to O.C.G.A.

§ 33-24-33(a), nor the signed insurance application contained any qualifying language specifying how many tanks, or which tanks, were insured; the meaning of the term “tanks” was plain and obvious.

Asphalt Ref. & Tech. Co., LLC v. Underwriters at Lloyd's London, No. 10-10863, 2011 U.S. App. LEXIS 1645 (11th Cir. Jan. 26, 2011) (Unpublished).

33-24-39. Insurers to furnish forms for proof of loss; effect of furnishing or failure to furnish forms.

RESEARCH REFERENCES

Am. Jur. Pleading and Practice Forms. — 14A Am. Jur. Pleading and Practice Forms, Insurance, § 4.

33-24-40. Acts of claims administration not to be deemed waiver of policies or defenses under policies.

JUDICIAL DECISIONS

Negotiating for settlement.

Insurer's offer to settle a homeowner's property damage claim did not waive a residency requirement in the policy or estop the insurer from denying coverage; O.C.G.A. § 33-24-40(3) precluded the settlement offer from being deemed a waiver. *Mahens v. Allstate Ins. Co.*, No. 11-12027, 2011 U.S. App. LEXIS 22478 (11th Cir. Nov. 4, 2011) (Unpublished).

Collection of information and investigation of loss not waiver of policy requirements.

Because an insured was on notice that, pursuant to O.C.G.A. § 33-24-40, the insurer did not waive any provision of a policy merely by investigating the insured's claim, and because there was no evidence that the insured was induced to delay filing a lawsuit until after the expiration of the one-year-period, the insurer was entitled to summary judgment. *Thornton v. Ga. Farm Bureau Mut. Ins. Co.*, 297 Ga. App. 132, 676 S.E.2d 814 (2009).

Settlement negotiations did not

constitute waiver of limitations period. — Insured's claim against an insurer, alleging a breach of the insured's insurance contract for failure to pay on a claim that resulted from a theft on the insured's premises, was properly found barred by the two-year limitations period contained in the insurance policy; the insurer's settlement negotiations did not lull the insured into believing that the insured did not have to file suit under O.C.G.A. § 33-24-40(3). *Stone Mt. Collision Ctr. v. General Cas. Co. of Wis.*, 307 Ga. App. 394, 705 S.E.2d 163 (2010).

Whether clause was waived is question for jury.

Summary judgment was improper since a question of fact remained as to whether the insurance company waived a contractual limitation when, after the limitations period expired, the adjuster informed the insured's counsel that the insurer might still consider payment. *Ogden v. Auto-owners Ins. Co.*, 2001 Ga. App. LEXIS 1049 (Aug. 31, 2001) (Unpublished).

33-24-41. Payment of claims under policies — Discharge of insurer by payment generally.

Law reviews. — For annual survey of insurance law, see 57 Mercer L. Rev. 221

(2005). For annual survey of insurance law, see 58 Mercer L. Rev. 181 (2006).

JUDICIAL DECISIONS

Notice obligations. — Because O.C.G.A. § 33-24-41 clearly discharged the insurer from liability when an individual did not notify it that the individual sought the proceeds of the insurance on

the individual's father's life, the trial court erred in denying the insurer's motion for summary judgment. *Colonial Life & Accident Ins. Co. v. Heveder*, 274 Ga. App. 377, 618 S.E.2d 39 (2005).

33-24-41.1. Motor vehicle accident claim covered by two or more insurance carriers; limited release.

Law reviews. — For annual survey on insurance, see 61 Mercer L. Rev. 179

(2009). For annual survey of law on insurance, see 62 Mercer L. Rev. 139 (2010).

JUDICIAL DECISIONS

Release did not extinguish uninsured motorist carrier's subrogation rights. — Injured insured's uninsured motorist insurer could sue a tortfeasor in subrogation as provided in O.C.G.A. § 33-7-11(f) even after the insured had released the tortfeasor from personal liability, pursuant to O.C.G.A. § 33-24-41.1, except to the extent that insurance coverage, other than the tortfeasor's personal liability policy, existed. *Ramos-Silva v. State Farm Mut. Ins. Co.*, 300 Ga. App. 699, 686 S.E.2d 345 (2009).

Settlement for less than policy limit. — To satisfy the exhaustion requirement of O.C.G.A. § 33-24-41.1, a carrier must offer and a claimant must accept an amount equal to the limit stated in the policy, not an amount less than the limit stated in the policy; accordingly, when an insured settled with a second person's carrier for less than the policy limit, the insured did not satisfy the exhaustion requirement and was not entitled to uninsured/underinsured motorist coverage from the insured's own insurer. *Holland v. Cotton States Mut. Ins. Co.*, 285 Ga. App. 365, 646 S.E.2d 477 (2007), cert. denied, 2007 Ga. LEXIS 619 (Ga. 2007).

Acceptance of settlement offer. — Trial court erred in granting the insureds' motion to enforce a settlement agreement a parent and an administrator allegedly reached with an insurer because the insurer's tender was not sufficient to constitute acceptance of the settlement offer; assuming that the offer by the parent and the administrator contemplated a legal impossibility or was in "tension" with the governing law, it did not follow that the insurer could accept something other than the offer made. *Kitchens v. Ezell*, No. A11A1242, 2012 Ga. App. LEXIS 290 (Mar. 16, 2012).

Injury claim and spouse's loss of consortium claim were injury to one person. — An injured wife and her husband satisfied the exhaustion requirement of O.C.G.A. § 33-24-41.1 and could proceed against their UM insurer; the husband's loss of consortium claim arose out of the wife's claim, so by settling both their claims for \$25,000, the other driver's per person limit, they exhausted the available coverage. *Mullinax v. State Farm Mut. Auto. Ins. Co.*, 303 Ga. App. 76, 692 S.E.2d 734 (2010).

33-24-44. Cancellation of policies generally.

Law reviews. — For annual survey of insurance law, see 58 Mercer L. Rev. 181

(2006). For annual survey of law on insurance, see 62 Mercer L. Rev. 139 (2010).

JUDICIAL DECISIONS

ANALYSIS

GENERAL CONSIDERATION

EXCEPTIONS

FORM, SUFFICIENCY, AND PROOF OF NOTICE

General Consideration

Supreme Court review of notice provisions authorized. — Question was certified to the state supreme court pursuant to O.C.G.A. § 15-2-9 as to whether a notice of cancellation, properly given by an insurer after the premium was past due, was ineffective under O.C.G.A. § 33-24-44 because the notice provided the insured an opportunity to keep the policy in force by paying the past due premium within the 10-day statutory period. *Infinity Gen. Ins. Co. v. Reynolds*, 570 F.3d 1228 (11th Cir. 2009).

Reinstatement retroactive to cancellation date for nonpayment not required. — In an insured's action against an automobile insurer that denied coverage, there was no issue of material fact as to whether the policy had been effectively cancelled for nonpayment. The insurer had mailed a notice of cancellation to the insured in accordance with O.C.G.A. § 33-24-44(d), and the insured, who did not recall seeing the notice, did not maintain that the mailing address was incorrect; moreover, although the policy was reinstated when the premium was received after the cancellation date, nothing in the policy required that the reinstatement be retroactive to the date of cancellation. *Zilka v. State Farm Mut. Auto. Ins. Co.*, 291 Ga. App. 665, 662 S.E.2d 777 (2008).

Applicability to termination of insurance agent. — O.C.G.A. § 33-24-44 governed the cancellation of insurance policies but did not govern the termination of insurance agents which may have had the ancillary effect of terminating an insurance policy, and thus, the court could not reasonably conclude that the retroactive termination of the financial planner was the harm § 33-24-44 was intended to guard against. Therefore, the financial planner did not allege a viable negligence per se claim and the negligence claims

against the insurance company were required to be dismissed. *Rosen v. Protective Life Ins. Co.*, No. 1:09-cv-03620-WSD, 2010 U.S. Dist. LEXIS 50392 (N.D. Ga. May 20, 2010).

Exceptions

Thirty-day notice for cancellation not required.

Trial court erred in finding that the insurance company had to give notice of cancellation for nonpayment of premiums under O.C.G.A. § 33-24-44, as that statute did not apply because the insurance contract stated that cancellation was automatic upon failure to pay premiums; thus, the trial court erred in granting summary judgment to a wife in an action to recover benefits under a life insurance policy. *Guideone Life Ins. Co. v. Ward*, 275 Ga. App. 1, 619 S.E.2d 723 (2005).

Form, Sufficiency, and Proof of Notice

Noncompliance with statutory requirements not excused.

Regardless of when it was generated, under O.C.G.A. § 33-24-45(d), an auto insurer's cancellation notice could not take effect until the date of mailing, at which point the insurer had received payment satisfying the insured's past-due balance. Therefore, cancellation for non-payment was improper under O.C.G.A. § 33-24-44. *Auto-Owners Ins. Co. v. Alexander*, 293 Ga. App. 459, 667 S.E.2d 628 (2008).

Notice that policy will be cancelled upon nonpayment of future premiums.

Upon the insured's failure to pay the insured's premiums on June 27, 2003, the insurer followed the proper procedure under Georgia law for cancellation of an insurance policy when the insurer sent a certified letter to the insured informing the insured of the payment problems and noticing the insured that the policy would

be cancelled if the premium was not paid by July 20, 2003; the insurer had no duty, under the original written policy, to defend the insured in any civil action arising from the July 31, 2003, crash since this was subsequent to the date coverage was cancelled due to nonpayment of premium. *Rutland v. State Farm Mut. Auto. Ins. Co.*, No. 10-10734, 2010 U.S. App. LEXIS 16744 (11th Cir. Aug. 12, 2010) (Unpublished).

Following procedures of company in giving notice of cancellation. — Insurer's evidence establishing that on the same date of the mailing receipt, the insureds were sent a cancellation notice, and that it was the insurer's practice to have cancellation notices inserted into envelopes manually or by machine before being matched to the appropriate mailing receipt, was sufficient to establish that the mailing contained a notice of cancellation sent to the insureds. *Burnside v. GEICO Gen. Ins. Co.*, 309 Ga. App. 897, 714 S.E.2d 606 (2011).

Issue of receipt of notice by insured irrelevant where section satisfied.

Because the mailing receipt and other uncontradicted evidence showed that the requisites of O.C.G.A. §§ 33-24-44 and 33-24-45(c) were satisfied, whether the insureds actually received notice of cancellation of their auto insurance policy was irrelevant and did not preclude the insurer from cancelling the insureds' pol-

icy due to non-payment. *Burnside v. GEICO Gen. Ins. Co.*, 309 Ga. App. 897, 714 S.E.2d 606 (2011).

Evidence of sufficient postage. — Manager's testimony that a cancellation notice was mailed to the insureds pursuant to the insurer's policies regarding the handling of mail was sufficient to establish that the notice was given the proper amount of postage. *Burnside v. GEICO Gen. Ins. Co.*, 309 Ga. App. 897, 714 S.E.2d 606 (2011).

Notice sufficient. — In response to a certified question, the Georgia Supreme Court held that a cancellation notice, given after an insurance premium was past due, which clearly stated that cancellation was occurring, was not ineffective simply because it also provided the insured with an opportunity to reinstate coverage. *Reynolds v. Infinity Gen. Ins. Co.*, 287 Ga. 86, 694 S.E.2d 337 (2010).

When an insured was in a car crash after an insurer canceled the policy for failing to pay the premium, the insurer had no duty to defend the insured because, *inter alia*, the insurer followed the proper procedure under Georgia law for cancellation of an insurance policy, and the insurer did not waive cancellation of the insured's policy by accepting a late premium payment. *Rutland v. State Farm Mut. Auto. Ins. Co.*, No. 10-10734, 2011 U.S. App. LEXIS 9859 (11th Cir. May 12, 2011) (Unpublished).

33-24-44.1. Procedure for cancellation by insured and notice.

JUDICIAL DECISIONS

Modification was not cancellation. — Trial court's grant of summary judgment to insurers in their declaratory judgment action, wherein it was determined that they owed no coverage obligations under a motorist's mother's policy to a driver who was involved in a collision with the motorist, was proper as the motorist's mother had not cancelled the policy when she sought deletion of the motorist's vehi-

cle therefrom and a new policy solely in the motorist's name; rather, the motorist had modified the existing policy and accordingly, the requirements for cancellation under O.C.G.A. § 33-24-44.1(a) were inapplicable. *Danforth v. Gov't Emples. Ins. Co.*, 282 Ga. App. 421, 638 S.E.2d 852 (2006), cert. denied, 2007 Ga. LEXIS 143 (Ga. 2007).

33-24-45. Cancellation or nonrenewal of automobile or motorcycle policies; procedure for review by Commissioner.

(a) This Code section shall apply only to those portions of an automobile policy or a motorcycle policy which relate to bodily injury and property damage liability, personal injury protection, medical payments, physical damage, and uninsured motorists' coverage.

(b) As used in this Code section, the term:

(1) "Policy" means a policy insuring a natural person as named insured or one or more related individuals resident of the same household and which provides bodily injury coverage and property damage liability coverage, personal injury protection, physical damage coverage, medical payments coverage, or uninsured motorists' protection coverage or any combination of coverages and under which the insured vehicles designated in the policy are of the following types only:

(A) Any motor vehicle of the private passenger, station wagon, or jeep type or a motorcycle that is not used as a public or livery conveyance for passengers nor rented to others; or

(B) Any other four-wheel motor vehicle with a load capacity of 1,500 pounds or less which is not used in the occupation or professional business of the insured; provided, however, that this Code section shall not apply to policies of automobile liability insurance issued under the Georgia Automobile Insurance Plan nor to any policy insuring an automobile which is one of more than four insured under a single policy nor to any policy covering garage, automobile sales agency, repair shop, service station, or public parking place operation hazards.

(2) "Renewal" means issuance and delivery by an insurer of a policy superseding at the end of the policy period a policy previously issued and delivered by the same insurer and providing no less than the coverage contained in the superseded policy or issuance and delivery of a certificate or notice extending the term of a policy beyond its policy period or term or the extension of the term of a policy beyond its policy period or term pursuant to a provision for extending the policy by payment of a continuation premium; provided, however, that any policy with a policy period or term of less than six months shall, for the purpose of this Code section, be considered to have successive policy periods ending each six months following its original date of issue and, regardless of its wording, any interim termination by its terms or by refusal to accept premium shall be a cancellation subject to this Code section, except in case of termination under any of the circumstances specified in subsection (f) of this Code

section; provided, further, that, for purposes of this Code section, any policy written for a term longer than one year or any policy with no fixed expiration date shall be considered as if written for successive policy periods or terms of one year and any termination by an insurer effective on an anniversary date of the policy shall be deemed a refusal to renew.

(c) No notice of cancellation of a policy issued for delivery in this state shall be mailed or delivered by an insurer or its agent duly authorized to effect such cancellation, except for one or more of the following reasons:

(1) The named insured failed to discharge when due any of his obligations in connection with the payment of premiums on such policy or any installment of premiums or the renewal of premiums, whether payable directly to the insurer or indirectly to the agent. Notwithstanding the provisions of subsection (d) of Code Section 33-24-44, such notice of cancellation issued to an insured, who is paying on a monthly basis, may be included with the bill issued to the insured, provided that the bill is mailed to the insured at least ten days prior to the due date;

(2) The issuance was obtained through a material misrepresentation;

(3) Any insured violated any of the terms and conditions of the policy;

(4) The named insured failed to disclose fully, if called for in the application, his record for the preceding 36 months of motor vehicle accidents and moving traffic violations;

(5) The named insured failed to disclose in his written application or in response to inquiry by his broker or by the insurer or its agent information necessary for the acceptance or proper rating of the risk;

(6) The named insured made a false or fraudulent claim or knowingly aided or abetted another in the presentation of such a claim;

(7) The named insured or any other operator either resident in the same household or who customarily operates an automobile insured under such policy:

(A) Has, within the 36 months prior to the notice of cancellation, had his driver's license under suspension or revocation;

(B) Is or becomes subject to epilepsy or heart attacks and the individual does not produce a certificate from a physician testifying to his unqualified ability to operate a motor vehicle;

(C) Has an accident record; a conviction record, criminal or traffic; or a physical, mental, or other condition which is such that his operation of an automobile might endanger the public safety;

(D) Has within a three-year period prior to the notice of cancellation been addicted to the use of narcotics or other drugs;

(E) Has been convicted or forfeited bail during the 36 months immediately preceding the notice of cancellation for:

(i) Any felony;

(ii) Criminal negligence resulting in death, homicide, or assault arising out of the operation of a motor vehicle;

(iii) Operating a motor vehicle while in an intoxicated condition or while under the influence of drugs;

(iv) Being intoxicated while in or about an automobile or while having custody of an automobile;

(v) Leaving the scene of an accident without stopping to report;

(vi) Theft or unlawful taking of a motor vehicle; or

(vii) Making false statements in an application for a driver's license; or

(F) Has been convicted of or forfeited bail for three or more violations, within the 36 months immediately preceding the notice of cancellation, of any law, ordinance, or regulation limiting the speed of motor vehicles or any of the provisions of the motor vehicle laws of any state, violation of which constitutes a misdemeanor, whether or not the violations were repetitions of the same offense or different offenses;

(8) The insured automobile:

(A) Is so mechanically defective that its operation might endanger public safety;

(B) Is used in carrying passengers for hire or compensation; provided, however, that the use of an automobile for a car pool shall not be considered use of an automobile for hire or compensation;

(C) Is used in the transportation of flammables or explosives;

(D) Is an authorized emergency vehicle; or

(E) Has changed in shape or condition during the policy period so as to increase substantially the risk.

(d) No notice of cancellation of a policy to which this Code section applies shall be effective unless mailed or delivered as prescribed in

Code Section 33-24-44. The insurer shall provide the reason or reasons for such cancellation as required by Chapter 39 of this title.

(e)(1) No insurer shall refuse to renew a policy to which this Code section applies unless a written notice of nonrenewal is mailed or delivered in person to the named insured. Such notice stating the time when nonrenewal will be effective, which shall not be less than 30 days from the date of mailing or delivery of such notice of nonrenewal or such longer period as may be provided in the contract or by statute, shall be delivered in person or by depositing the notice in the United States mails to be dispatched by at least first-class mail to the last address of record of the insured and of the lienholder, where applicable, and receiving the receipt provided by the United States Postal Service or such other evidence of mailing as prescribed or accepted by the United States Postal Service.

(2) The insurer shall specify in writing the reason or reasons for such nonrenewal as required by Chapter 39 of this title.

(3) No notice refusing the renewal of a policy issued for delivery in this state shall be mailed or delivered by an insurer or its agent duly authorized to effect such notice of nonrenewal for the following reasons:

(A) Lack of, lack of potential for, or failure to agree to a writing of supporting insurance business;

(B) A change in the insurer's eligibility rules or underwriting rules, provided that this subparagraph shall not apply to a change in such rules if the change applies uniformly within a specific class or territory and such change has been approved by the Commissioner under subparagraph (B) of paragraph (4) of this subsection;

(C) With respect to any driver or with respect to any automobile or its replacement, except when the replacement is such that together with other relevant underwriting or eligibility rules it would not have been insured as an original policy risk of the insurer, for two or fewer of the following within the preceding 36 month period:

(i) Accidents involving two or more motor vehicles in which the driver of the insured automobile under this subparagraph was not at fault;

(ii) Uninsured or underinsured motorist coverage claims;

(iii) Comprehensive coverage claims; and

(iv) Towing or road service coverage claims;

(D) Age, sex, location of residence address within the state, race, creed, national origin, ancestry, or marital status;

(E) Lawful occupation, provided that the insured automobile is not used in such occupation and provided, further, that such automobile would have been insured as an original policy risk of the insurer when such occupation is considered together with other relevant underwriting or eligibility rules of the insurer;

(F) Military service, provided that the named insured has no change of legal residence from this state;

(G) Number of years of driving experience of a named insured or of any other operator who is either a resident in the same household or customarily an operator of an automobile insured under such policy;

(H) Accidents or violations which occurred more than 36 months prior to the expiration date or anniversary date of the policy or solely for claims paid or payable pursuant to the policy during the preceding 36 month period which did not aggregate in an amount in excess of \$750.00;

(I) One claim against the policy based on fault if such coverage has been in effect continuously for at least 36 preceding months;

(J) Notwithstanding subparagraph (I) of this paragraph, two claims against the policy based on fault if such coverage has been in effect continuously for at least 72 preceding months; and

(K) Factors not relating to the claims record, driving record, or driving ability of the named insured or of any other operator who is either a resident in the same household or customarily an operator of an automobile insured under such policy.

(4)(A) Notwithstanding paragraph (3) of this subsection, any reason set forth in subsection (c) of this Code section, relating to cancellation, shall also constitute a reason for nonrenewal.

(B) If the insurer demonstrates to the satisfaction of the Commissioner that renewal would violate the provisions of this title or would be hazardous to its policyholders or the public, subparagraph (B) or (K) of paragraph (3) shall not apply.

(5)(A) If the insurer complies with paragraph (1) of this subsection, no claim or action may be maintained with respect to a policy which is not renewed unless the named insured files a written notice with the insurer before the time at which nonrenewal becomes effective. The notice shall specify the manner in which the failure to renew is alleged to be unlawful under this subsection. In any subsequent action asserting a violation of this subsection, no violation of this subsection may be alleged other than the specific allegations contained in the notice filed by the named insured.

(B) In addition to other requirements, a notice of nonrenewal shall contain the provisions of subparagraph (A) of this paragraph, in substantially the form which follows:

“NOTICE

Code Section 33-24-45 of the Official Code of Georgia Annotated provides that this insurer must, upon request, furnish you with the reasons for the failure to renew this policy. If you wish to assert that the nonrenewal is unlawful, you must file a written notice with this insurer before the time at which the nonrenewal becomes effective. The notice must specify the manner in which the failure to renew is alleged to be unlawful.

If you do not file the written notice, you may not later assert a claim or action against this insurer based upon an unlawful nonrenewal.”

(6)(A) Notwithstanding paragraph (3) of this subsection, the termination of an agency relationship shall be valid as a reason for a failure to renew a policy. In such case, if the named insured wishes to retain the policy with the particular insurer, the insured shall locate another agent of the insurer and apply for the policy with another agent of the insurer before the time at which the nonrenewal becomes effective. Upon receipt of the application, the insurer shall treat the application as a renewal and not as an original writing. Nothing in this subparagraph shall abridge or supersede contractual rights of the terminated agency or the insurer, provided that these contractual rights do not adversely affect the privilege of the named insured to apply for renewal through another agent of the insurer.

(B) A notice of nonrenewal based upon the termination of an agency relationship shall contain the provisions of subparagraph (A) of this paragraph, in substantially the form which follows:

“NOTICE

Your policy has not been renewed because your present agent no longer represents this insurer. You have the option of procuring coverage through your present agent or retaining this policy by applying through another agent of this insurer. Code Section 33-24-45 of the Official Code of Georgia Annotated provides that if you will locate another agent of this insurer and apply for this policy before the time at which the nonrenewal becomes effective, this insurer will treat the application as a renewal and not as an application for a new policy.”

(f) Subsection (e) of this Code section shall not apply in case of:

(1) Nonpayment of premium for the expiring policy;

(2) Failure of the insured to pay the premium as required by the insurer for renewal; or

(3) The insurer having manifested its willingness to renew by delivering a renewal policy, renewal certificate, or other evidence of renewal to the named insured or his representative or by offering to issue a renewal policy, certificate, or other evidence of renewal or having manifested such intention by any other means.

(g) Notwithstanding the failure of an insurer to comply with this Code section, termination of any coverage under the policy either by cancellation or nonrenewal shall be effective on the effective date of any other policy providing similar coverage on the same motor vehicle or any replacement of coverage.

(h) Renewal or continuation of a policy shall not constitute a waiver or estoppel with respect to ground for cancellation which existed before the effective date of the renewal or continuance.

(i) When a policy is canceled other than for nonpayment of premium or in the event of a refusal to renew or continue a policy, the insurer shall notify the named insured of his possible eligibility for insurance through the Georgia Automobile Insurance Plan. Such notice shall accompany or be included in the notice of cancellation or the notice of intent not to renew or not to continue the policy and shall state that such notice of availability of the Georgia Automobile Insurance Plan is given pursuant to this Code section.

(j) There shall be no liability on the part of and no cause of action of any nature shall arise against the Commissioner or his employees or against any insurer, its authorized representatives, its agents, its employees, or any firm, person, or corporation furnishing to the insurer information as to reasons for cancellation or nonrenewal for any statement made by any of them in any written notice of cancellation or nonrenewal or in any other communication, oral or written, specifying the reasons for cancellation or nonrenewal or providing information pertaining to the reasons for cancellation or nonrenewal or for statements made or evidence submitted at any formal or informal hearing conducted in connection with the reasons for cancellation or nonrenewal of the insured's policy.

(k) This Code section shall not apply to any policy which has been in effect less than 60 days at the time notice of cancellation is mailed or delivered by the insurer unless it is a renewal of a policy. Such policies shall be canceled in accordance with Code Section 33-24-44.

(l) Return of unearned premium, if any, due to cancellations as to which this Code section applies shall be processed in accordance with Code Section 33-24-44.

(m) Notice to the insured shall not be required by this Code section when a policy is canceled by an insurance premium finance company under a power of attorney contained in an insurance premium finance agreement if notification of the existence of the premium finance agreement has been given to the insurer in accordance with the provisions of Chapter 22 of this title. However, the insurer shall comply with the provisions of subsection (d) of Code Section 33-22-13 pertaining to notice to a governmental agency, mortgagee, or other third party. Such notice shall be delivered in person or by depositing the notice in the United States mails to be dispatched by at least first-class mail to the last address of record of such governmental agency, mortgagee, or other third party and receiving the receipt provided by the United States Postal Service or such other evidence of mailing as prescribed or accepted by the United States Postal Service.

(n) Cancellation by the insured shall be accomplished as provided in Code Section 33-24-44.1.

(o) An insured may request a review by the Commissioner if the insured believes that his or her policy has been canceled or nonrenewed in violation of this Code section. Such request must be filed with the Commissioner within 15 days of receipt of a notice of cancellation or nonrenewal. A review of the cancellation or nonrenewal shall be conducted within 30 days of said request. The Commissioner shall notify the insured and the insurer of his or her decision within the 30 day period. During the pendency of such review, the policy shall continue in full force and effect and the Commissioner shall specify by rule or regulation the method of payment of premium due and the disposition of premium refunds, if any. The Commissioner shall either require that the policy be reinstated or renewed or may uphold the nonrenewal or cancellation. In the event the Commissioner determines that an insurer's cancellation or nonrenewal action constitutes an unfair act or practice, the Commissioner may take action as authorized by this title. Following the completion of any review provided by this subsection, an insured may request a hearing pursuant to Code Section 33-2-17, and nothing in this subsection shall be deemed to waive an insured's right to request such a hearing. (Code 1933, § 56-2430.1, enacted by Ga. L. 1968, p. 1126, § 1; Ga. L. 1971, p. 658, §§ 1-5; Ga. L. 1975, p. 1242, §§ 2, 3; Ga. L. 1982, p. 3, § 33; Ga. L. 1984, p. 1345, § 5; Ga. L. 1987, p. 1466, § 3; Ga. L. 1988, p. 677, §§ 1, 2; Ga. L. 1991, p. 1608, §§ 1.8, 1.9, 1.10, 1.11; Ga. L. 1996, p. 705, § 15; Ga. L. 1996, p. 767, § 1; Ga. L. 2005, p. 60, § 33/HB 95; Ga. L. 2012, p. 1117, § 6/SB 385.)

The 2012 amendment, effective July 1, 2012, added the last sentence in paragraph (c)(1).

JUDICIAL DECISIONS

ANALYSIS

GENERAL CONSIDERATION
EFFECTIVENESS OF NOTICE**General Consideration**

Renewal versus new policy. — Because an insurance policy was issued by the same insurer to supersede an existing policy and to extend the term of the existing policy beyond its policy period conditioned upon payment of a continuation premium, the fact that it bore a slightly different number and that there were changes in the premium amounts and the vehicles insured did not mean that it was a new policy rather than a renewal under O.C.G.A. § 33-24-45(b)(2). Thus, uninsured motorist coverage was not the \$1,000,000 liability limit under O.C.G.A. § 33-7-11(a), but the \$25,000 per person limit that the insureds had previously selected. *Roberson v. Leone*, No. A11A1972, 2012 Ga. App. LEXIS 324 (Mar. 22, 2012).

Effect of payment made after cancellation. — While insureds made a payment after sustaining auto damage and after allegedly learning for the first time that the insureds' coverage had been cancelled for non-payment, the insurer's receipt of this payment resulted in the reinstatement of the policy the following day. Thus, the insureds' intent in making payment after the fact was irrelevant to whether the insureds' policy was cancelled at the time of the accident. *Burnside v. GEICO Gen. Ins. Co.*, 309 Ga. App. 897, 714 S.E.2d 606 (2011).

Cited in *Infinity Gen. Ins. Co. v. Litton*, 308 Ga. App. 497, 707 S.E.2d 885 (2011).

Effectiveness of Notice

Notice ineffective as notice of cancellation.

Regardless of when it was generated, under O.C.G.A. § 33-24-45(d), an auto in-

surer's cancellation notice could not take effect until the date of mailing, at which point the insurer had received payment satisfying the insured's past-due balance. Therefore, cancellation for non-payment was improper under O.C.G.A. § 33-24-44. *Auto-Owners Ins. Co. v. Alexander*, 293 Ga. App. 459, 667 S.E.2d 628 (2008).

Notice effective. — In response to a certified question, the Georgia Supreme Court held that a cancellation notice, given after an insurance premium was past due, which clearly stated that cancellation was occurring, was not ineffective under O.C.G.A. § 33-24-45(c)(1) simply because it also provided the insured with an opportunity to reinstate coverage. *Reynolds v. Infinity Gen. Ins. Co.*, 287 Ga. 86, 694 S.E.2d 337 (2010).

Insurer's evidence establishing that on the same date of the mailing receipt, the insureds were sent a cancellation notice, and that it was the insurer's practice to have cancellation notices inserted into envelopes manually or by machine before being matched to the appropriate mailing receipt, was sufficient to establish that the mailing contained a notice of cancellation sent to the insureds. *Burnside v. GEICO Gen. Ins. Co.*, 309 Ga. App. 897, 714 S.E.2d 606 (2011).

Because the mailing receipt and other uncontradicted evidence showed that the requisites of O.C.G.A. §§ 33-24-44 and 33-24-45(c) were satisfied, whether the insureds actually received notice of cancellation of the insureds auto insurance policy was irrelevant and did not preclude the insurer from cancelling the insureds' policy due to non-payment. *Burnside v. GEICO Gen. Ins. Co.*, 309 Ga. App. 897, 714 S.E.2d 606 (2011).

33-24-51. Purchase of insurance covering injuries resulting from governmental ownership and use of motor vehicles; waiver of governmental immunity; limitation of liabilities.

Law reviews. — For annual survey of administrative law, see 56 Mercer L. Rev. 31 (2004). For annual survey of construction law, see 56 Mercer L. Rev. 109 (2004). For annual survey of local government law, see 56 Mercer L. Rev. 351 (2004). For annual survey of local government law,

see 58 Mercer L. Rev. 267 (2006). For survey article on insurance law, see 60 Mercer L. Rev. 191 (2008). For survey article on local government law, see 60 Mercer L. Rev. 263 (2008). For annual survey of law on insurance, see 62 Mercer L. Rev. 139 (2010).

JUDICIAL DECISIONS

ANALYSIS

GENERAL CONSIDERATION WAIVER OF IMMUNITY APPLICABILITY

General Consideration

Definition of “motor vehicle”. — In determining if a county waived the county’s sovereign immunity through the voluntary purchase of liability insurance under the second sentence of O.C.G.A. § 33-24-51(b), a trial court erred in considering the definition of “motor vehicle” provided in O.C.G.A. § 36-92-1; rather, “any motor vehicle” was defined as a vehicle that was capable of being driven on the public roads that was covered by a liability insurance policy purchased by the county. *Glass v. Gates*, 311 Ga. App. 563, 716 S.E.2d 611 (2011).

Waiver does not apply to intentional conduct. — It is clear from the text of O.C.G.A. § 33-24-51(b) that the waiver is meant to encompass negligent acts, not intentional ones. *Williams v. Dekalb County*, No. 07-14367, 2009 U.S. App. LEXIS 9839 (11th Cir. May 6, 2009) (Unpublished).

Waiver of Immunity

Construction of subsection (b).

Trial court erred in dismissing the farmers’ tort claims based on sovereign immunity because the date that an action was filed did not determine whether the 1991 amendment to Ga. Const. 1983, Art. I, Sec. II, Para. IX controlled; as a truck was used for spreading sewage sludge on the farm-

ers’ property, damages resulting from the spreading of the sludge from the truck were injuries arising by reason of use of the truck for purposes of O.C.G.A. § 33-24-51(b). *McElmurray v. Augusta-Richmond County*, 274 Ga. App. 605, 618 S.E.2d 59 (2005).

O.C.G.A. § 33-24-51 subject to waiver of immunity provision.

In an arrestee’s 42 U.S.C. § 1983 suit against a lead pursuit deputy and the supervisor for using excessive force to stop the arrestee’s car during a high-speed chase, the county was not entitled to sovereign immunity under Ga. Const. 1983, Art. I, Sec. II, Para. IX(d) from liability for negligence because the county waived its immunity pursuant to O.C.G.A. § 33-24-51(b) by purchasing liability insurance coverage to cover the negligence of county employees arising from the use of a motor vehicle. *Harris v. Coweta County*, No. 3:01-CV-148-WBH, 2003 U.S. Dist. LEXIS 27348 (N.D. Ga. Sept. 25, 2003).

Immunity waived to extent of liability insurance.

In a tort action for personal injuries and property damage arising from an auto collision filed against a city and its police officer, the trial court erred in granting a city summary judgment, as: (1) O.C.G.A. § 40-6-6(d)(2) did not apply; and (2) the city waived its sovereign immunity to the

extent that it purchased liability coverage to cover the officer's actions in operating that officer's police car. But, the trial court properly granted summary judgment to the officer, given that the officer was engaged in a discretionary function of responding to an emergency situation at the time the accident at issue occurred. *Weaver v. City of Statesboro*, 288 Ga. App. 32, 653 S.E.2d 765 (2007), cert. denied, 2008 Ga. LEXIS 221 (Ga. 2008).

Immunity waived by purchase of insurance. — County was not entitled to sovereign immunity in an estate's claim arising from the death of an inmate because the county had bought the type of insurance defined in O.C.G.A. § 33-24-51; the estate claimed that the inmate's death resulted from an officer's negligent supervision of the inmate's actions in maintaining a tractor by trying to replace a tire. The policy covered negligence for autos, the tractor was an auto under the statute and the policy, and the policy covered maintenance of a covered auto, which included changing a tire. *McDuffie v. Coweta County*, 299 Ga. App. 500, 682 S.E.2d 609 (2009).

Summary judgment based on sovereign immunity improper. — Trial court erred in granting a police officer and a city summary judgment, on the ground that the officer was performing a discretionary duty and the city was protected by sovereign immunity, in an arrestee's action to recover damages for injuries sustained when the officer ran over the arrestee's foot with a patrol car during the arrest. A jury would be authorized to find that the officer did not act intentionally, but rather, negligently came too close to the arrestee with the car for the purposes that the officer was trying to achieve and used poor judgment under the circumstances; there was an issue of fact on whether the arrestee assumed the risk of injury because it was not beyond dispute that the arrestee was aware of the actual risk of being hit by the officer or that the arrestee had subjective knowledge that the arrestee was at risk of being hit from behind by a police car being driven by a trained officer when the arrestee had not threatened the officer with deadly force. *Davis v. Batchelor*, 300 Ga. App. 662, 686 S.E.2d 314 (2009).

Applicability

Negligence must arise from "ownership, maintenance, operation, or use" of vehicle.

A county sued by a motorcyclist who was injured on a closed road did not waive sovereign immunity under O.C.G.A. § 33-24-51. The claim did not arise from the use of an excavator that was parked on the road as the excavator was not involved in the accident, was not under the control of the county, but by the contractor that owned and insured the excavator, and was not being operated by any agent or employee of the county. *Williams v. Whitfield County*, 289 Ga. App. 301, 656 S.E.2d 584 (2008).

Use of vehicle too remote in time. — County's use of a pot-patcher vehicle the day before an accident was too remote in time to constitute "use" of the vehicle sufficient to waive sovereign immunity pursuant to O.C.G.A. § 33-24-51. *Bd. of Comm'rs v. Barefoot*, 313 Ga. App. 406, 721 S.E.2d 612 (2011).

Portable tar kettle machine. — In a worker's suit alleging negligence on the part of a county with regard to the county allegedly failing to properly instruct and supervise the worker in the use of a portable tar kettle machine, the trial court erred by granting the county's motion for a judgment on the pleadings based on sovereign immunity as the worker sufficiently alleged that the machine was a vehicle as contemplated by O.C.G.A. § 33-24-51, which established a waiver of sovereign immunity if the county had purchased liability insurance to cover damages and injuries arising from the use of motor vehicles under the county's management. *Hewell v. Walton County*, 292 Ga. App. 510, 664 S.E.2d 875 (2008).

No waiver of immunity regarding negligence unconnected with motor vehicles.

In an action arising out of an arrest, despite the way the arrestee was treated, the trial court properly dismissed a complaint against a county, and granted summary judgment on the same complaint against a city, on sovereign immunity grounds because the arrestee failed to show that the immunity had been waived.

Scott v. City of Valdosta, 280 Ga. App. 481, 634 S.E.2d 472 (2006).

Trial court erred in denying a city and the city's police officers summary judgment as to an arrestee's claims against the city and the officers in the officers official capacities because the claim against one of the officers in the officer's official capacity was, in reality, a suit against a governmental entity and subject to a claim of sovereign immunity, and no genuine issue of fact remained as to whether the city waived the city's sovereign immunity pursuant to O.C.G.A. § 33-24-51; the alleged negligence was unrelated to the use of a motor vehicle. *Campbell v. Goode*, 304 Ga. App. 47, 695 S.E.2d 44 (2010).

Trial court erred in denying a motion for summary judgment filed by a county and a paramedic with the county emergency medical services in a patient's spouse's action alleging that the paramedic acted negligently in the paramedic's assessment of the patient because the county and paramedic were shielded from liability by sovereign and official immunity, and there was no waiver of sovereign immunity under the motor vehicle exception found in O.C.G.A. § 33-24-51 since the liability of the county and paramedic was not predicated on their alleged negligent use of an ambulance as a motor vehicle; there was no evidence that the ambulance and the ambulance's use played any part in the paramedic's diagnosis of or choice of treatment for the patient, and thus, the county ambulance was, at best, tangentially related to the paramedic's failure to use a cardiac monitor on the patient. *Polk County v. Ellington*, 306 Ga. App. 193, 702 S.E.2d 17 (2010).

Sovereign immunity barred the claimants' personal injury and nuisance claims against the members of a county board of commissioners in the commissioners' official capacities because the claimants did not show that the county waived the county's sovereign immunity with regard to the county's operation of a mosquito control helicopter which sprayed one of the claimants with chemicals. Further, the county did not waive the county's sovereign immunity under O.C.G.A. § 33-24-51 by purchasing a liability insurance policy covering the helicopter because the heli-

copter was not a "motor vehicle" as that term was understood in the statute. *Bd. of Comm'rs v. Johnson*, 311 Ga. App. 867, 717 S.E.2d 272 (2011).

County sheriff and deputy. — In a wrongful death suit brought after a patrol car driven by a deputy sheriff struck and killed the decedent, the sheriff and the deputy were not entitled to summary judgment on the claims against them in their official capacity; under O.C.G.A. § 33-24-51, they could be held liable to the extent that the county waived its sovereign immunity by the purchase of automobile liability insurance. *Nichols v. Prather*, 286 Ga. App. 889, 650 S.E.2d 380 (2007), cert. denied, 2007 Ga. LEXIS 766 (Ga. 2007).

In a parent's wrongful death action, the trial court did not err by granting summary judgment to a county sheriff and a county deputy sheriff on the basis of sovereign immunity because, at the time of the son's suicide, the deputy's vehicle was essentially being used as a holding cell and did not relate to the use of the patrol car as a vehicle pursuant to O.C.G.A. § 33-24-51. *Gish v. Thomas*, 302 Ga. App. 854, 691 S.E.2d 900 (2010).

County may be liable for negligence of convict while maintaining county roads.

A worker's suit against a county brought after the worker stepped into an open manhole was barred by sovereign immunity. O.C.G.A. § 33-24-51(a) did not apply as no evidence supported the worker's allegation that a county employee mowing in the area with a tractor had knocked the manhole cover off or had a duty to inspect and report a missing cover. *Dunn v. Telfair County*, 288 Ga. App. 200, 653 S.E.2d 537 (2007).

Intentional conduct of officer in beating arrestee. — Arrestee's state law claims against a county for false imprisonment, kidnapping, and aggravated assault in connection with a police officer's transporting of the arrestee to a wooded area and subsequent beating and stabbing of the arrestee were barred under the doctrine of sovereign immunity, and the waiver of immunity in O.C.G.A. § 33-24-51(b) did not apply because although the officer used an insured patrol

car to transport the arrestee, the officer's acts were intentional, not negligent. *Williams v. Dekalb County*, No. 07-14367, 2009 U.S. App. LEXIS 9839 (11th Cir. May 6, 2009) (Unpublished).

Known hazard in road. — Trial court erred in denying a county's motion for summary judgment in a driver's action alleging that the county was negligent for failing to maintain and repair a roadway and/or failing to warn of a known hazard

because there was no evidence that the county waived the county's sovereign immunity under O.C.G.A. § 36-92-2, and there was no evidence that a county vehicle caused the hole in the roadway; the plaintiff, not the defendants, has the burden of establishing that a county waived sovereign immunity by purchasing liability insurance protection covering his or her claim. *Effingham County v. Rhodes*, 307 Ga. App. 504, 705 S.E.2d 856 (2010).

RESEARCH REFERENCES

Am. Jur. Proof of Facts. — Negligent Vehicular Police Chase, 41 POF2d 79.

33-24-53. Compensation for referrals or recommendations to attorneys prohibited; penalties.

(a) In a claim arising out of a motor vehicle accident, a lawyer shall not compensate or give anything of value to a person or organization to recommend or secure his employment by a client, or as a reward for having made a recommendation resulting in his employment by a client; except that he may pay for public communications permitted by Standard 5 of Bar Rule 4-102 and the usual and reasonable fees or dues charged by a bona fide lawyer referral service operated by an organization authorized by law and qualified to do business in this state; provided, however, such organization has filed with the State Disciplinary Board, at least annually, a report showing its terms, its subscription charges, agreements with counsel, the number of lawyers participating, and the names and addresses of lawyers participating in the service. Upon conviction of an offense provided for by this subsection, the prosecutor shall certify such conviction to the disciplinary board of the State Bar of Georgia for appropriate action. Such action may include a suspension or disbarment.

(b) With respect to a motor vehicle insurance benefit or claim, a health care provider shall not compensate or give anything of value to a person to recommend or secure the provider's service to or employment by a patient or as a reward for having made a recommendation resulting in the provider's service to or employment by a patient, except that the provider may pay the reasonable cost of advertising or written communication as permitted by rules of professional conduct. Upon a conviction of an offense provided for by this subsection, the prosecutor shall certify such conviction to the appropriate boards for appropriate action. Such action may include a suspension or revocation of the health care provider's license.

(c) With respect to a motor vehicle accident, no employee of any law enforcement agency or the Department of Transportation shall allow

any person, including an attorney, health care provider, or their agents, to examine or obtain a copy of any accident report or related investigative report when the employee knows or should reasonably know that the request for access to the report is for commercial solicitation purposes. No person shall request any law enforcement agency or the Department of Transportation to permit examination or to furnish a copy of any such report for commercial solicitation purposes. For purposes of this subsection, a request to examine or obtain a copy of a report is for “commercial solicitation purposes” if made at a time when there is no relationship between the person or his or her principal requesting the report and any party to the accident, and there is no apparent reason for the person to request the report other than for purposes of soliciting a business or commercial relationship. All persons, except law enforcement personnel and persons named in the report, shall be required to submit a separate written request to the law enforcement agency or the Department of Transportation for each report. Such written request shall state the requestor’s name, address, and the intended use of the report in sufficient detail that the law enforcement agency or the Department of Transportation may ascertain that the intended use is not for commercial solicitation purposes. The law enforcement agency or the Department of Transportation shall file each written request with the original report. No person shall knowingly make any false statement in any such written request.

(d) A person may not receive compensation, a reward, or anything of value in return for providing names, addresses, telephone numbers, or other identifying information of victims involved in motor vehicle accidents to an attorney or health care provider which results in employment of the attorney or health care provider by the victims for purposes of a motor vehicle insurance claim or suit. Attempts to circumvent this Code section through use of any other person, including, but not limited to, employees, agents, or servants, shall also be prohibited. This provision shall not prohibit an attorney or health care provider from making a referral and receiving compensation as is permitted under applicable professional rules of conduct.

(e) Any person who violates any provision of this Code section shall be guilty of a misdemeanor involving moral turpitude. (Code 1981, § 33-24-53, enacted by Ga. L. 1991, p. 1864, § 2; Ga. L. 2011, p. 583, § 9/HB 137; Ga. L. 2012, p. 775; § 33/HB 942.)

The 2011 amendment, effective July 1, 2011, in subsection (c), inserted “or the Department of Transportation” throughout, inserted “or her” in the third sentence, and deleted a comma following “in the report” in the fourth sentence.

The 2012 amendment, effective May 1, 2012, part of an Act to revise, modernize, and correct the Code, revised punctuation in the fourth sentence of subsection (c).

33-24-54. Payments to nonparticipating or nonpreferred providers of health care services.

(a) Notwithstanding any provisions of Code Sections 33-1-3, 33-1-5, and 33-24-17 and Chapter 20 of this title or any other provisions of this title which might be construed to the contrary, whenever an accident and sickness insurance policy, subscriber contract, or self-insured health benefit plan, by whatever name called, which is issued or administered by a person licensed under this title provides that any of its benefits are payable to a participating or preferred provider of health care services licensed under the provisions of Chapter 4 of Title 26 or of Chapter 9, 11, 30, 34, 35, or 39 of Title 43 or of Chapter 11 of Title 31 for services rendered, the person licensed under this title shall be required to pay such benefits either directly to any similarly licensed nonparticipating or nonpreferred provider who has rendered such services, has a written assignment of benefits, and has caused written notice of such assignment to be given to the person licensed under this title or jointly to such nonparticipating or nonpreferred provider and to the insured, subscriber, or other covered person; provided, however, that in either case the person licensed under this title shall be required to send such benefit payments directly to the provider who has the written assignment. When payment is made directly to a provider of health care services as authorized by this Code section, the person licensed under this title shall give written notice of such payment to the insured, subscriber, or other covered person.

(b) Nothing contained in this Code section shall be deemed to prohibit the payment of different levels of benefits or from having differences in coinsurance percentages applicable to benefit levels for services provided by participating or preferred providers and nonparticipating or nonpreferred providers as otherwise authorized under the provisions of Code Sections 33-30-20 through 33-30-27.

(c) Payments made by a person licensed under this title under subsection (a) of this Code section to a nonparticipating or nonpreferred provider or jointly to the provider and the insured, subscriber, or other covered person shall discharge such person's obligation with respect to the amount so paid.

(d) The provisions of this Code section shall not apply to credit insurance, disability income insurance, or limited accident and sickness policies such as hospital indemnity policies, specified disease policies, limited accident policies, or similar limited policies. (Code 1981, § 33-24-54, enacted by Ga. L. 1992, p. 1184, § 2; Ga. L. 2006, p. 652, § 4/HB 1257.)

The 2006 amendment, effective July 1, 2006, inserted “or of Chapter 11 of Title 31” near the middle of subsection (a).

33-24-56.1. Reimbursement of medical expense or disability benefit providers in personal injury cases; subrogation prohibited; notice.

Law reviews. — For survey article on trial practice and procedure, see 59 Mercer L. Rev. 423 (2007).

For note, “ERISA Subrogation and the

Controversy Over Sereboff: Silencing the Critics, the Divided Bench is a Legitimate Standard,” see 45 Ga. L. Rev. 579 (2011).

JUDICIAL DECISIONS

Federal preemption. — Georgia’s anti-subrogation statute, O.C.G.A. § 33-24-56.1, did not apply to prevent a welfare benefit plan from enforcing its reimbursement claim against an employee because the plan was exempt from the statute by virtue of the deemer clause in 29 U.S.C. § 1144(b)(2)(B). *Summerlin v. Georgia-Pacific Corp. Life, Health and Accident Plan*, 366 F. Supp. 2d 1203 (M.D. Ga. 2005).

Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq., did not preempt O.C.G.A. § 33-24-56.1 because the state statute was directed toward the insurance industry, and affects the risk pooling arrangement between the insurer and the insured. *Smith v. Life Ins. Co. of N. Am.*, 466 F. Supp. 2d 1275 (N.D. Ga. 2006).

ERISA plan administrator off-set. — Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq., plan administrator was prevented from off-setting a participant’s monthly disability under Georgia’s anti-subrogation statute, O.C.G.A. § 33-24-56.1 (2004). *Smith v. Life Ins. Co. of N. Am.*, 466 F. Supp. 2d 1275 (N.D. Ga. 2006).

Complete compensation rule inap-

plicable due to federal statute. — Since there was no conflict between state law and federal interests, an action by a state service benefit plan for reimbursement from a plan beneficiary after a settlement with a third party under the Federal Employees Health Benefits Act of 1959 (FEHBA) lacked subject matter jurisdiction under 28 U.S.C. § 1331 and had to be dismissed. There was no conflict because Georgia courts determined that when the FEHBA applied, the complete compensation rule under O.C.G.A. § 33-24-56.1(b) did not apply. *Blue Cross Blue Shield Health Care Plan of Ga., Inc. v. Gunter*, 541 F.3d 1320 (11th Cir. 2008).

Insurer not entitled to setoff following Medicare payment. — A trial court erred by dismissing an insured’s uninsured motorist (UM) benefits suit against the insured’s UM carrier as the insured’s settlement with the tortfeasor was reduced by the amount of a Medicare lien; therefore, the insured’s UM recovery should not have been reduced (nor rejected) under the complete compensation doctrine. *Toomer v. Allstate Ins. Co.*, 292 Ga. App. 60, 663 S.E.2d 763 (2008).

Cited in *Lamb v. Salvation Army*, 301 Ga. App. 325, 687 S.E.2d 615 (2009).

33-24-56.3. Colorectal cancer screening and testing.

(a) As used in this Code section, the term:

(1) “Health benefit policy” means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, executed, or renewed by an insurer in this state on or after

July 1, 2002, including, but not limited to, those contracts executed by the Department of Community Health pursuant to paragraph (1) of subsection (d) of Code Section 31-2-4. The term “health benefit policy” does not include the following limited benefit insurance policies: accident only, CHAMPUS supplement, dental, disability income, fixed indemnity, long-term care, medicare supplement, specified disease, vision, and nonrenewable individual policies written for a period of less than six months.

(2) “Insurer” means any person, corporation, or other entity authorized to provide health benefit policies under this title.

(b) Every health benefit policy shall provide coverage for colorectal cancer screening, examinations, and laboratory tests in accordance with the most recently published guidelines and recommendations established by the American Cancer Society, in consultation with the American College of Gastroenterology and the American College of Radiology, for the ages, family histories, and frequencies referenced in such guidelines and recommendations and deemed appropriate by the attending physician after conferring with the patient.

(c) The benefits provided in this Code section shall be subject to the same annual deductibles or coinsurance established for all other covered benefits within a given health benefit policy. (Code 1981, § 33-24-56.3, enacted by Ga. L. 2002, p. 1089, § 1; Ga. L. 2009, p. 453, § 1-41/HB 228.)

The 2009 amendment, effective July 1, 2009, substituted “subsection (d) of Code Section 31-2-4” for “subsection (f) of Code Section 31-5A-4” at the end of the first sentence of paragraph (a)(1).

33-24-56.4. Payment for telemedicine services.

(a) This Code section shall be known and may be cited as the “Georgia Telemedicine Act.”

(b) As used in this Code section, the term:

(1) “Health benefit policy” means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, executed, or renewed in this state, including, but not limited to, those contracts executed by the State of Georgia on behalf of state employees under Article 1 of Chapter 18 of Title 45, by an insurer.

(2) “Insurer” means an accident and sickness insurer, fraternal benefit society, hospital service corporation, medical service corporation, health care corporation, health maintenance organization, preferred provider organization, provider sponsored health care corporation, managed care entity, or any similar entity authorized to issue contracts under this title or to provide health benefit policies.

(3) “Telemedicine” means the practice, by a duly licensed physician or other health care provider acting within the scope of such provider’s practice, of health care delivery, diagnosis, consultation, treatment, or transfer of medical data by means of audio, video, or data communications which are used during a medical visit with a patient or which are used to transfer medical data obtained during a medical visit with a patient. Standard telephone, facsimile transmissions, unsecured e-mail, or a combination thereof do not constitute telemedicine services.

(c) It is the intent of the General Assembly to mitigate geographic discrimination in the delivery of health care by recognizing the application of and payment for covered medical care provided by means of telemedicine, provided that such services are provided by a physician or by another health care practitioner or professional acting within the scope of practice of such health care practitioner or professional and in accordance with the provisions of Code Section 43-34-31.

(d) On and after July 1, 2005, every health benefit policy that is issued, amended, or renewed shall include payment for services that are covered under such health benefit policy and are appropriately provided through telemedicine in accordance with Code Section 43-34-31 and generally accepted health care practices and standards prevailing in the applicable professional community at the time the services were provided. The coverage required in this Code section may be subject to all terms and conditions of the applicable health benefit plan. (Code 1981, § 33-24-56.4, enacted by Ga. L. 2005, p. 481, § 3/HB 291; Ga. L. 2009, p. 859, § 11/HB 509; Ga. L. 2011, p. 752, § 33/HB 142.)

The 2009 amendment, effective July 1, 2009, substituted “Code Section 43-34-31” for “Code Section 43-34-31.1” at the end of subsection (c) and in the middle of the first sentence of subsection (d).

The 2011 amendment, effective May 13, 2011, part of an Act to revise, modernize, and correct the Code, substituted “e-mail” for “electronic mail” in the last sentence of paragraph (b)(3).

33-24-58.2. Newborn Baby and Mother Protection Act — Minimum health benefit policy coverage; prohibited actions by insurance providers; required notice to mother.

(a) As used in this Code section, the term:

(1) “Attending provider” means:

(A) Pediatricians and other physicians attending the newborn; and

(B) Obstetricians, other physicians, and certified nurse midwives attending the mother.

(2) "Health benefit policy" means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, or renewed in this state, including those contracts executed by the State of Georgia on behalf of indigents and on behalf of state employees under Article 1 of Chapter 18 of Title 45, by a health care corporation, health maintenance organization, preferred provider organization, accident and sickness insurer, fraternal benefit society, hospital service corporation, medical service corporation, or other insurer or similar entity.

(3) "Insurer" means an accident and sickness insurer, fraternal benefit society, hospital service corporation, medical service corporation, health care corporation, health maintenance organization, or any similar entity authorized to issue contracts under this title and also means any state program funded under Title XIX of the federal Social Security Act, 42 U.S.C.A. Section 1396, et seq., and any other publicly funded state health care program.

(b) Every health benefit policy that provides maternity benefits that is delivered, issued, executed, or renewed in this state or approved for issuance or renewal in this state by the Commissioner on or after July 1, 1996, shall provide coverage for a minimum of 48 hours of inpatient care following a normal vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section for a mother and her newly born child in a licensed health care facility.

(c) Any decision to shorten the length of stay to less than that provided under subsection (b) of this Code section shall be made by the attending physician, the obstetrician, pediatrician, or certified nurse midwife after conferring with the mother.

(d) If a mother and newborn are discharged pursuant to subsection (c) of this Code section prior to the postpartum inpatient length of stay provided under subsection (b) of this Code section, coverage shall be provided for up to two follow-up visits, provided that the first such visit shall occur within 48 hours of discharge. Such visits shall be conducted by a physician, a physician assistant, or a registered professional nurse with experience and training in maternal and child health nursing. After conferring with the mother, the health care provider shall determine whether the initial visit will be conducted at home or at the office. Thereafter, he or she shall confer with the mother and determine whether a second visit is appropriate and where it shall be conducted. Services provided shall include, but not be limited to, physical assessment of the newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, and the performance of any medically necessary and appropriate clinical tests. Such services shall be consistent with protocols and guidelines developed by national pediatric, obstetric, and nursing professional organizations for these services.

(e) The Commissioner shall adopt rules and regulations necessary to implement the provisions of this Code section.

(f) Every insurer shall provide notice to policyholders regarding the coverage required by this Code section. The notice shall be in writing and prominently positioned in any of the following literature:

- (1) The next mailing to the policyholder;
- (2) The yearly informational packets sent to the policyholder; or
- (3) Other literature mailed before January 1, 1997.

In addition to such notice, the insurer shall also provide a notice to the expectant mother within 30 days following the date the insurer first learns that the expectant mother covered by maternity benefits of the health benefit policy is pregnant in substantially the following form:

“NOTICE

The Newborn Baby and Mother Protection Act (Code Section 33-24-58.2 of the O.C.G.A.) requires that health benefit policies which provide maternity benefits must provide coverage for a minimum of 48 hours of inpatient care following a normal vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section for a mother and her newborn child. The care must be provided in a licensed health care facility. A decision to shorten the length of stay may be made only by the attending health care provider after conferring with the mother. If the stay is shortened, coverage must be provided for up to two follow-up visits with specified health care providers with the first visit being within 48 hours after discharge. After conferring with the mother, the health care provider must determine whether the initial visit will be conducted at home or at the office and whether a second visit is appropriate. Specified services are required to be provided at such visits.”

(g) No insurer covered under this Code section shall deselect, terminate the services of, require additional utilization review, reduce capitation payment, or otherwise penalize an attending physician or other health care provider who orders care consistent with the provisions of this Code section. For purposes of this subsection, health care provider shall be defined to include the attending physician, certified nurse midwife, and hospital. (Code 1981, § 33-24-58.2, enacted by Ga. L. 1996, p. 409, § 1; Ga. L. 2002, p. 613, § 1; Ga. L. 2005, p. 60, § 33/HB 95; Ga. L. 2009, p. 859, § 3/HB 509.)

The 2009 amendment, effective July 1, 2009, substituted “physician assistant” for “physician’s assistant” in the second sentence of subsection (d).

33-24-59.2. Coverage for equipment and self-management training for individuals with diabetes; enforcement.

(a) On or after July 1, 2002, every individual major medical and group health insurance policy, group health insurance plan or policy, and any other form of managed or capitated care plans or policies shall provide coverage for medically necessary equipment, supplies, pharmacologic agents, and outpatient self-management training and education, including medical nutrition therapy, for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and noninsulin-using diabetes who adhere to the prognosis and treatment regimen prescribed by a physician licensed to practice medicine pursuant to Title 43.

(b)(1) Diabetes outpatient self-management training and education as provided for in subsection (a) of this Code section shall be provided by a certified, registered, or licensed health care professional with expertise in diabetes.

(2) The office of the Commissioner of Insurance shall promulgate rules and regulations after consultation with the Department of Public Health which conform to the current standards for diabetes outpatient self-management training and educational services established by the American Diabetes Association for purposes of this Code section.

(3) The office of the Commissioner of Insurance shall promulgate rules and regulations, relating to standards of diabetes care, to become effective July 1, 2002, after consultation with the Department of Human Resources (now known as the Department of Public Health for these purposes), the American Diabetes Association, and the National Institutes of Health. Such rules and regulations shall be adopted in accordance with the provisions of Code Section 33-2-9.

(c) The benefits provided in this Code section shall be subject to the same annual deductibles or coinsurance established for all other covered benefits within a given policy.

(d) Private third-party payors may not reduce or eliminate coverage due to the requirements of this Code section.

(e) Enforcement of the provisions of this Code section shall be performed by the Commissioner of Insurance. (Code 1981, § 33-24-59.2, enacted by Ga. L. 1998, p. 660, § 1; Ga. L. 2002, p. 646, § 1; Ga. L. 2009, p. 453, § 1-42/HB 228; Ga. L. 2011, p. 705, § 6-3/HB 214.)

The 2009 amendment, effective July 1, 2009, substituted “Department of Community Health” for “Department of Human Resources” in paragraph (b)(2) and

inserted “(now known as the Department of Community Health for these purposes)” in paragraph (b)(3).

The 2011 amendment, effective July 1, 2011, substituted “Department of Pub-

lic Health” for “Department of Community Health” in paragraphs (b)(2) and (b)(3).

Law reviews. — For article on the 2011 amendment of this Code section, see 28 Ga. St. U. L. Rev. 147 (2011).

33-24-59.5. (Effective January 1, 2013. See note.) Definitions; timely payment of health benefits; notification of failure to pay; penalties; applicability.

(a) As used in this Code section, the term:

(1) “Benefits” means the coverages provided by a health benefit plan for financing or delivery of health care goods or services; but such term does not include capitated payment arrangements under managed care plans.

(2) (Effective January 1, 2013. See note.) “Health benefit plan” means any hospital or medical insurance policy or certificate, health care plan contract or certificate, qualified higher deductible health plan, health maintenance organization subscriber contract, any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45, or any dental or vision care plan or policy, or managed care plan or self-insured plan; but health benefit plan does not include policies issued in accordance with Chapter 31 of this title; disability income policies; or Chapter 9 of Title 34, relating to workers’ compensation.

(3) (Effective January 1, 2013. See note.) “Insurer” means an accident and sickness insurer, fraternal benefit society, nonprofit hospital service corporation, nonprofit medical service corporation, health care corporation, health maintenance organization, provider sponsored health care corporation, or any similar entity and any self-insured health benefit plan, which entity provides for the financing or delivery of health care services through a health benefit plan, the plan administrator of any health plan, or the plan administrator of any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45 or any other administrator as defined in paragraph (1) of subsection (a) of Code Section 33-23-100.

(b)(1) (Effective January 1, 2013. See note.) All benefits under a health benefit plan will be payable by the insurer which is obligated to finance or deliver health care services under that plan upon such insurer’s receipt of written or electronic proof of loss or claim for payment for health care goods or services provided. The insurer shall within 15 working days for electronic claims or 30 calendar days for paper claims after such receipt mail or send electronically to the insured or other person claiming payments under the plan payment for such benefits or a letter or electronic notice which states the

reasons the insurer may have for failing to pay the claim, either in whole or in part, and which also gives the person so notified a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. Where the insurer disputes a portion of the claim, any undisputed portion of the claim shall be paid by the insurer in accordance with this chapter. When all of the listed documents or other information needed to process the claim has been received by the insurer, the insurer shall then have 15 working days for electronic claims or 30 calendar days for paper claims within which to process and either mail payment for the claim or a letter or notice denying it, in whole or in part, giving the insured or other person claiming payments under the plan the insurer's reasons for such denial.

(2) Receipt of any proof, claim, or documentation by an entity which administrates or processes claims on behalf of an insurer shall be deemed receipt of the same by the insurer for purposes of this Code section.

(c) (Effective January 1, 2013. See note.) Each insurer shall pay to the insured or other person claiming payments under the health benefit plan interest equal to 12 percent per annum on the proceeds or benefits due under the terms of such plan for failure to comply with subsection (b) of this Code section.

(d) (Effective January 1, 2013. See note.) An insurer may only be subject to an administrative penalty by the Commissioner as authorized by the insurance laws of this state when such insurer processes less than 95 percent of all claims in a standard financial quarter in compliance with paragraph (1) of subsection (b) of this Code section. Such penalty shall be assessed on data collected by the Commissioner.

(e) (Effective January 1, 2013. See note.) This Code section shall be applicable when an insurer is adjudicating claims for its fully insured business or its business as a third-party administrator. (Code 1981, § 33-24-59.5, enacted by Ga. L. 1999, p. 289, § 2; Ga. L. 2005, p. 60, § 33/HB 95; Ga. L. 2011, p. 595, § 5/HB 167.)

Delayed effective date. — This Code section, as set forth above, is effective on January 1, 2013. For the version of this Code section effective until that date, see the bound volume.

The 2011 amendment, effective January 1, 2013, inserted “or self-insured plan” near the middle of paragraph (a)(2); in paragraph (a)(3), deleted “not subject to the exclusive jurisdiction of the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et

seq.” following “self-insured health benefit plan”, inserted “the plan administrator of any health plan” near the end, and added “or any other administrator as defined in paragraph (1) of subsection (a) of Code Section 33-23-100” at the end; in paragraph (b)(1), in the second and fourth sentences, inserted “for electronic claims or 30 calendar days for paper claims”, inserted “or electronic” near the end of the first sentence, inserted “or send electronically” near the middle of the second sen-

tence; substituted “12 percent” for “18 percent” in subsection (c); and added subsections (d) and (e).

Editor’s notes. — Ga. L. 2011, p. 595,

§ 1, not codified by the General Assembly, provides that: “This Act shall be known and may be cited as the ‘Insurance Delivery Enhancement Act of 2011.’”

33-24-59.7. Coverage for the treatment of morbidly obese patients; short title; legislative findings; adoption of rules and regulations by Commissioner.

(a) This Code section shall be known and may be cited as the “Morbid Obesity Anti-discrimination Act.”

(b) The General Assembly finds and declares that:

(1) Whereas many health care insurers cover the costs of treatment for patients diagnosed as morbidly obese by their physicians, many other insurers refuse to cover such costs;

(2) There is sufficient scientific data that implicate morbid obesity as the cause of many other medical problems and costly health complications, such as diabetes, hypertension, heart disease, and stroke. These data indirectly question the safety and appropriateness of the continued refusal of some insurers to cover the medically indicated treatment of the morbidly obese patient. The association of morbid obesity with the aforementioned devastating diseases refutes any claim of a purely cosmetic indication for the treatment of morbid obesity and clearly designates morbid obesity as a life-threatening disease;

(3) The cost of managing the complications of morbid obesity, largely due to inadequate treatment, far outweighs the cost of expeditious, effective medical treatment. Therefore, insurers who continue to refuse to pay for the primary treatment of morbid obesity are contributing to the high cost of management of secondary complications;

(4) Guidelines developed by the National Institute of Health, the American Society for Bariatric Surgery, the American Obesity Association, and Shape Up America and embraced by the American Medical Association and the American College of Surgeons recommend that patients who are morbidly obese receive responsible, affordable medical treatment for their obesity; and

(5) The diagnosis of morbid obesity should be a clinical decision made by a physician based on the guidelines set by the appropriate health and medical associations and organizations. The treatment modality should also be a clinical decision made by the physician based on set guidelines.

(c)(1) As used in this Code section, the term:

(A) "Health benefit policy" means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, or renewed in this state which provides major medical benefits, including those contracts executed by the State of Georgia on behalf of indigents and on behalf of state employees under Article 1 of Chapter 18 of Title 45, by a health care corporation, health maintenance organization, preferred provider organization, accident and sickness insurer, fraternal benefit society, hospital service corporation, medical service corporation, or other insurer or similar entity.

(B) "Health care providers" means those physicians and medical institutions that are specifically qualified to treat in a comprehensive manner the entire complex of illness and disease associated with morbid obesity.

(C) "Insurer" means an accident and sickness insurer, fraternal benefit society, hospital service corporation, medical service corporation, health care corporation, health maintenance organization, or any similar entity authorized to issue contracts under this title and also means any state program funded under Title XIX of the federal Social Security Act, 42 U.S.C.A. Section 1396 et seq., and any other publicly funded state health care program.

(D) "Morbid obesity" means a weight which is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables. Morbid obesity also means a body mass index (BMI) equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes or a BMI of 40 kilograms per meter squared without such comorbidity. BMI equals weight in kilograms divided by height in meters squared.

(2) Every health benefit policy that is delivered, issued, executed, or renewed in this state or approved for issuance or renewal in this state by the Commissioner on or after July 1, 1999, which provides major medical benefits may offer coverage for the treatment of morbid obesity.

(d) The Commissioner of Insurance shall adopt rules and regulations necessary to implement the provisions of this Code section in collaboration with the Department of Public Health and in compliance with current guidelines established by professional medical organizations relating to the treatment of morbid obesity. (Code 1981, § 33-24-59.7, enacted by Ga. L. 1999, p. 368, § 1; Ga. L. 2009, p. 453, § 1-4/HB 228; Ga. L. 2011, p. 705, § 6-1/HB 214.)

The 2009 amendment, effective July 1, 2009, substituted “Department of Community Health” for “Department of Human Resources” in subsection (d).

The 2011 amendment, effective July 1, 2011, substituted “Department of Pub-

lic Health” for “Division of Public Health of the Department of Community Health” in subsection (d).

Law reviews. — For article on the 2011 amendment of this Code section, see 28 Ga. St. U. L. Rev. 147 (2011).

RESEARCH REFERENCES

Am. Jur. Proof of Facts. — Discrimination Against the Obese, 36 POF2d 249.

33-24-59.13. Exemptions from certain unfair trade practices for certain wellness and health improvement programs; incentives.

(a) An insurer issuing life, comprehensive, major medical group, or individual health insurance benefit plans may, in keeping with federal requirements, offer wellness or health improvement programs, including voluntary wellness or health improvement programs that provide for rewards or incentives, including, but not limited to, merchandise, gift cards, debit cards, premium discounts, credits or rebates, contributions towards a member’s health savings account, modifications to copayment, deductible, or coinsurance amounts, cash value, or any combination of these incentives, to encourage participation in such wellness or health improvement programs and to reward insureds for participation in such programs.

(b) The offering of such rewards or incentives to insureds under such wellness or health improvement programs shall not be considered an unfair trade practice under Code Section 33-6-4 if such programs are filed with the Commissioner and made a part of the life or health insurance master policy and certificates or the individual life or health insurance evidence of coverage as a policy amendment, endorsement, rider, or other form of policy material as agreed upon by the Commissioner. The Commissioner shall be authorized to develop an automatic or expedited approval process for review of such wellness or health improvement programs, including those programs already approved under the laws and regulations of other states. (Code 1981, § 33-24-59.13, enacted by Ga. L. 2010, p. 755, § 2/SB 411; Ga. L. 2012, p. 1080, § 1/SB 337.)

Effective date. — This Code section became effective July 1, 2010.

The 2012 amendment, effective July 1, 2012, in subsection (a), inserted “life,”

near the beginning, inserted “, credits” near the middle, and inserted “cash value,” near the end; and twice inserted “life or” in subsection (b).

33-24-59.14. (Effective January 1, 2013) Definitions; prompt pay requirements; penalties.

(a) As used in this Code section, the term:

(1) "Administrator" shall have the same meaning as provided in Code Section 33-23-100.

(2) "Benefits" shall have the same meaning as provided in Code Section 33-24-59.5.

(3) "Facility" shall have the same meaning as provided in Code Section 33-20A-3.

(4) "Health benefit plan" shall have the same meaning as provided in Code Section 33-24-59.5.

(5) "Health care provider" shall have the same meaning as provided in Code Section 33-20A-3.

(6) "Insurer" means an accident and sickness insurer, fraternal benefit society, nonprofit hospital service corporation, nonprofit medical service corporation, health care corporation, health maintenance organization, provider sponsored health care corporation, or any similar entity, which entity provides for the financing or delivery of health care services through a health benefit plan, the plan administrator of any health plan, or the plan administrator of any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45.

(b)(1) All benefits under a health benefit plan will be payable by the insurer or administrator which is obligated to finance or deliver health care services or process claims under that plan upon such insurer's or administrator's receipt of written or electronic proof of loss or claim for payment for health care goods or services provided. The insurer or administrator shall within 15 working days for electronic claims or 30 calendar days for paper claims after such receipt mail or send electronically to the facility or health care provider claiming payments under the plan payment for such benefits or a letter or notice which states the reasons the insurer or administrator may have for failing to pay the claim, either in whole or in part, and which also gives the facility or health care provider so notified a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. Where the insurer or administrator disputes a portion of the claim, any undisputed portion of the claim shall be paid by the insurer or administrator in accordance with this chapter. When all of the listed documents or other information needed to process the claim have been received by the insurer or administrator, the insurer or

administrator shall then have 15 working days for electronic claims or 30 calendar days for paper claims within which to process and either mail payment for the claim or a letter or notice denying it, in whole or in part, giving the facility or health care provider claiming payments under the plan the insurer's or administrator's reasons for such denial.

(2) Receipt of any proof, claim, or documentation by an entity which administers or processes claims on behalf of an insurer shall be deemed receipt of the same by the insurer for purposes of this Code section.

(c) Each insurer or administrator shall pay to the facility or health care provider claiming payments under the health benefit plan interest equal to 12 percent per annum on the proceeds or benefits due under the terms of such plan for failure to comply with subsection (b) of this Code section.

(d) An insurer or administrator may only be subject to an administrative penalty by the Commissioner as authorized by the insurance laws of this state when such insurer or administrator processes less than 95 percent of all claims in a standard financial quarter in compliance with paragraph (1) of subsection (b) of this Code section. Such penalty shall be assessed on data collected by the Commissioner.

(e) This Code section shall be applicable when an insurer is adjudicating claims for its fully insured business or its business as a third-party administrator.

(f) This Code section shall not apply to limited benefit insurance policies. For the purpose of this subsection, the term "limited benefit insurance" means accident or sickness insurance designed, advertised, and marketed to supplement major medical insurance and specifically shall include accident only, CHAMPUS supplement, disability income, fixed indemnity, long-term care, or specified disease insurance. (Code 1981, § 33-24-59.14, enacted by Ga. L. 2011, p. 595, § 6/HB 167.)

Effective date. — This Code section becomes effective January 1, 2013.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2011, Code Section 33-24-59.14 as enacted by Ga. L. 2011, p. 609, § 2, was redesignated as Code Section 33-24-59.15.

Editor's notes. — Ga. L. 2011, p. 595, § 1, not codified by the General Assembly, provides that: "This Act shall be known and may be cited as the 'Insurance Delivery Enhancement Act of 2011.'"

33-24-59.15. Definitions; dental insurance.

(a) As used in this Code section:

(1) "Covered dental services" means dental care services for which a reimbursement is available under a covered person's dental benefit

plan, or for which a reimbursement would be available but for the application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.

(2) “Covered person” means any subscriber, enrollee, member, beneficiary, or participant, or his or her dependent, for whom benefits are payable when that covered person receives dental care services rendered or authorized by a dentist licensed under Chapter 11 of Title 43.

(3) “Dental benefit plan” means any individual or group plan, policy, contract, or subscription agreement which includes or is for dental care services that is issued, delivered, issued for delivery, or renewed in this state whether by a health care insurer, health maintenance organization, preferred provider organization, accident and sickness insurer, fraternal benefit society, nonprofit hospital service corporation, nonprofit medical or dental service corporation, health care plan, or any other person, firm, corporation, joint venture, or other similar business entity that pays for, purchases, or furnishes dental care services to patients, insureds, beneficiaries, or covered dependents in this state.

(4) “Dental insurer” means any person, firm, corporation, joint venture, or other similar business entity that offers dental benefit plans in consideration of periodic payments.

(b) No contract between a dental insurer and a dentist shall require a dentist to accept an amount set by the dental insurer as payment for dental care services that are not covered dental services under the covered person’s dental benefit plan.

(c) A dental insurer or other person or entity providing third-party administrator services shall not make available any providers in its dentist network to a plan that sets dental fees for any services except covered services.

(d) A dental insurer shall not draft, publish, disseminate, or circulate explanation of benefit forms that include language which directly or indirectly implies that a dentist may or should extend discounts to patients for noncovered dental services. Statements by a dental insurer which are prohibited by this Code section include but are not limited to, “Our members value the services you provide and we encourage you to continue extending the discount on noncovered services.” (Code 1981, § 33-24-59.15, enacted by Ga. L. 2011, p. 609, § 2/HB 189.)

Effective date. — This Code section became effective July 1, 2011.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2011, Code

Section 33-24-59.14 as enacted by Ga. L. 2011, p. 609, § 2, was redesignated as Code Section 33-24-59.15.

Editor's notes. — Ga. L. 2011, p. 609,

§ 1, not codified by the General Assembly, provides that: "This Act shall be known and may be cited as the 'Noncovered Dental Services Act.'"

ARTICLE 3

BREAST CANCER PATIENT CARE

33-24-72. Mastectomy; lymph node dissection; coverage for in-patient care and follow-up visits required by health insurers; notice to policyholders.

(a) As used in this Code section, the term:

(1) "Attending physician" means any surgeon or other physician attending the breast cancer patient.

(2) "Health benefit policy" means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, or renewed in this state, including, but not limited to, those contracts executed by the State of Georgia on behalf of indigents and on behalf of state employees under Article 1 of Chapter 18 of Title 45, by a health care corporation, health maintenance organization, preferred provider organization, accident and sickness insurer, fraternal benefit society, hospital service corporation, medical service corporation, or other insurer or similar entity; except that such term does not include any policy of limited benefit insurance as defined in paragraph (4) of subsection (e) of Code Section 33-30-12.

(3) "Insurer" means an accident and sickness insurer, fraternal benefit society, hospital service corporation, medical service corporation, health care corporation, health maintenance organization, managed care plan other than a dental plan, or any similar entity authorized to issue contracts under this title and also means any state program funded under Title XIX of the federal Social Security Act, 42 U.S.C.A. Section 1396 et seq., and any other publicly funded state health care program.

(4) "Lymph node dissection" means the removal of a part of the lymph node system under the arm using general anesthesia as part of a diagnostic process that is used to evaluate the spread of cancer and to determine the need for further treatment.

(5) "Mastectomy" means surgical removal of one or both breasts.

(b) Every health benefit policy that provides surgical benefits for mastectomies that is delivered, issued, executed, or renewed in this state or approved for issuance or renewal in this state by the Commissioner on or after July 1, 1999, shall provide coverage in a licensed

health care facility for inpatient care following a mastectomy or lymph node dissection until the completion of the appropriate period of stay for such inpatient care as determined by the attending physician in consultation with the patient. Coverage shall be provided also for such number of follow-up visits as determined to be appropriate by the attending physician after consultation with the patient. Such follow-up visits shall be conducted by a physician, a physician assistant, or a registered professional nurse with experience and training in postsurgical care. In consultation with the patient, such attending physician, physician assistant, or registered professional nurse shall determine whether any follow-up visit or visits will be conducted at home or at the office.

(c) Every insurer shall provide notice to policyholders regarding the coverage required by this Code section. The notice shall be in writing and prominently positioned in any of the following literature:

- (1) The next mailing to the policyholder;
- (2) The yearly informational packets sent to the policyholder; or
- (3) Other literature mailed before January 1, 2000.

(d) No insurer covered under this Code section shall deselect, terminate the services of, require additional utilization review, reduce capitation payment, or otherwise penalize an attending physician or other health care provider who orders care consistent with the provisions of this Code section. For purposes of this subsection, health care provider shall include the attending physician and hospital. (Code 1981, § 33-24-72, enacted by Ga. L. 1999, p. 319, § 1; Ga. L. 2009, p. 859, § 3/HB 509.)

The 2009 amendment, effective July 1, 2009, substituted “physician assistant” for “physician’s assistant” twice in subsection (b).

CHAPTER 25

LIFE INSURANCE

Sec.

33-25-11. Cash surrender value and proceeds of life insurance policies and annuity contracts not liable to attachment, garnishment, or legal process in favor

of creditors; proceeds payable to insured’s estate, executor, administrator, or assign to become part of insured’s estate.

RESEARCH REFERENCES

Am. Jur. Proof of Facts. — Decedent's Intent to Change Beneficiary of Life Insurance Policy, 1 POF2d 437.

Fraudulent Cancellation of Life Insurance, 5 POF2d 587.

Innocent Misrepresentation of Physical Condition by Applicant for Life or Health Insurance, 23 POF2d 53.

Fact of Death, 28 POF2d 81.

Materiality of Applicant's Misrepresentation in Application for Life or Health Insurance, 3 POF3d 367.

Litigating the Suicide Exclusion in Life Insurance Policies, 20 POF3d 705.

Insurer's Liability for Improper Issuance or Maintenance of Life Insurance Policy, Prompting Murder or Attempted Murder of Insured, 37 POF3d 149.

Substantial Compliance with Requirements of Life Insurance Policy Regarding Change of Beneficiary, 44 POF3d 377.

33-25-1. "Contract of life insurance" defined.

RESEARCH REFERENCES

Am. Jur. Pleading and Practice Forms. — 14A Am. Jur. Pleading and Practice Forms, Insurance, § 153.

33-25-3. Required policy provisions generally.

JUDICIAL DECISIONS

Grace period. — In a case in which a life insurance policy lapsed for nonpayment of premiums before the insured died and the beneficiaries, relying on O.C.G.A. § 33-25-3(a)(1), asserted that the insured died during the contestability time period, the beneficiaries had no right to recover under the contract. The insurance company's letter to the insured did not indicate

that the grace period was extended, only that the lapsed coverage could be reinstated, and § 33-25-3(a)(1) only required that a 30 day grace period be included in life insurance contracts, and there was no dispute that the contract at issue met that prerequisite. *White v. New York Life Ins. Co.*, 564 F. Supp. 2d 1372 (S.D. Ga. 2008).

33-25-10. Payment of interest on proceeds or payments under policies.

JUDICIAL DECISIONS

No prejudgment interest if insured dies within 12 months of issuance of policy.

In an insurer's 28 U.S.C. § 1335 interpleader suit to determine whether a trust, a decedent's children with his first wife, or the decedent's second wife and any children they may have had together were entitled to the decedent's life insur-

ance policy proceeds, the trust, which was determined to be entitled to the proceeds, was not entitled to interest under O.C.G.A. § 33-25-10(b)(2), as that statute specifically stated that interest on policy proceeds did not accrue during the pendency of an interpleader action. *Nat'l Life Ins. Co. v. Alembik-Eisner*, 582 F. Supp. 2d 1362 (N.D. Ga. 2008).

33-25-11. Cash surrender value and proceeds of life insurance policies and annuity contracts not liable to attachment, garnishment, or legal process in favor of creditors; proceeds payable to insured's estate, executor, administrator, or assign to become part of insured's estate.

(a) Whenever any person residing in the state shall die leaving insurance on his or her life, such insurance shall inure exclusively to the benefit of the person for whose use and benefit such insurance is designated in the policy, and the proceeds thereof shall be exempt from the claims of creditors of the insured unless the insurance policy or a valid assignment thereof provides otherwise. Whenever the insurance, by designation or otherwise, is payable to the insured or to the insured's estate or to his or her executors, administrators, or assigns, the insurance proceeds shall become a part of the insured's estate for all purposes and shall be administered by the personal representative of the estate of the insured in accordance with the probate laws of the state in like manner as other assets of the insured's estate.

(b) Payments as directed in this Code section shall, in every such case, discharge the insurer from any further liability under the policy, and the insurer shall in no event be responsible for, or be required to see to, the application of such payments.

(c) The cash surrender values of life insurance policies issued upon the lives of citizens or residents of this state, upon whatever form, shall not in any case be liable to attachment, garnishment, or legal process in favor of any creditor of the person whose life is so insured unless the insurance policy was assigned to or was effected for the benefit of such creditor or unless the purchase, sale, or transfer of the policy is made with the intent to defraud creditors. (Ga. L. 1933, p. 181, § 1; Code 1933, § 56-905; Code 1933, § 56-2505, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 2006, p. 885, § 1/HB 1304.)

The 2006 amendment, effective May 5, 2006, rewrote this Code section.

JUDICIAL DECISIONS

Scope of protection. — O.C.G.A. § 33-25-11 more narrowly protects cash surrender value from “attachment, garnishment, and legal process,” but does not purport to exempt it from all claims of creditors. *Roach v. Ryan* (In re Ryan), No. 11-40712, 2012 Bankr. LEXIS 784 (Bankr. S.D. Ga. Jan. 17, 2012).

Does not apply in bankruptcy. —

O.C.G.A. § 44-13-100, by the statute's express terms, applies to bankruptcy debtors. By contrast, nothing in the history or language of O.C.G.A. § 33-25-11(c) indicates the legislature intended that statute to apply in bankruptcy; therefore, § 33-25-11(c) is unavailable for purposes of exempting property from a debtor's bankruptcy estate. In *re Dean*, No.

11-53329-JDW, 2012 Bankr. LEXIS 1220 (Bankr. M.D. Ga. Mar. 20, 2012).

33-25-13. Receipt of benefits from insurance policy of deceased by person found guilty of committing murder or voluntary manslaughter.

Law reviews. — For annual survey of insurance law, see 56 Mercer L. Rev. 253 (2004).

For note, “Vesting Title in a Murderer:

Where is the Equity in the Georgia Supreme Court’s Interpretation of the Slayer Statute in Levenson?,” see 45 Ga. L. Rev. 877 (2011).

JUDICIAL DECISIONS

Rights of those who kill by accident or negligence not impaired. — Statutes that embody the public policy of Georgia of prohibiting wrongdoers from profiting from their crimes, O.C.G.A. §§ 17-14-31, 33-25-13, and 53-1-5, only prevent those who feloniously and intentionally kill, O.C.G.A. § 53-1-5(a), or those who commit murder or voluntary manslaughter, O.C.G.A. § 33-25-13, from sharing, respectively, in the decedent’s estate or insurance policy proceeds; if a public policy may be gleaned from these statutes, it is a policy that prohibits those who commit murder or voluntary manslaughter from profiting from the victim’s death, but these statutes do not impair the rights of those who kill by accident or negligence, who kill in self-defense or pursuant to any other legal justification, or who kill while legally insane because simply admitting to having committed a homicide does not make one a wrongdoer under Georgia law. *Bruscato v. O’Brien*, 307 Ga. App. 452, 705 S.E.2d 275 (2010).

Evidence of conviction.

Because a husband had been convicted of killing his wife, the estate executors were entitled to summary judgment for an order of distribution of life insurance proceeds under O.C.G.A. § 33-25-13. The husband’s criminal conviction was prima

facie evidence under O.C.G.A. § 24-4-3 that he was guilty of his wife’s murder for the purpose of determining that he could not receive proceeds of an insurance policy on her life. *Cont’l Cas. Co. v. Adamo*, No. 08-10130, 2008 U.S. App. LEXIS 13979 (11th Cir. July 1, 2008) (Unpublished).

Existence of genuine issue of fact as to whether beneficiary was perpetrator. — Summary judgment was improperly granted to a beneficiary in an insurer’s interpleader action to determine whether the beneficiary was entitled to the life insurance policy proceeds of the insured, the beneficiary’s wife, because evidence that the insured died of a gunshot wound while in Mexico, that the beneficiary was carrying a gun while in Mexico, and that the beneficiary lied about the insured’s cause of death created a genuine issue of fact as to whether the beneficiary’s recovery was barred under O.C.G.A. § 33-25-13; the fact that the beneficiary had been acquitted of the insured’s murder had no impact on the outcome of the civil case because the civil case had a different burden of proof. *Cantera v. Am. Heritage Life Ins. Co.*, 274 Ga. App. 307, 617 S.E.2d 259 (2005).

Cited in *Tolbert v. State*, 282 Ga. 254, 647 S.E.2d 555 (2007); *Levenson v. Word*, 294 Ga. App. 104, 668 S.E.2d 763 (2008).

CHAPTER 26

INDUSTRIAL LIFE INSURANCE

RESEARCH REFERENCES

Am. Jur. Proof of Facts. — Decedent's Intent to Change Beneficiary of Life Insurance Policy, 1 POF2d 437.

Fraudulent Cancellation of Life Insurance, 5 POF2d 587.

Innocent Misrepresentation of Physical Condition by Applicant for Life or Health Insurance, 23 POF2d 53.

Materiality of Applicant's Misrepresentation in Application for Life or Health Insurance, 3 POF3d 367.

Litigating the Suicide Exclusion in Life Insurance Policies, 20 POF3d 705.

Insurer's Liability for Improper Issuance or Maintenance of Life Insurance Policy, Prompting Murder or Attempted Murder of Insured, 37 POF3d 149.

Substantial Compliance with Requirements of Life Insurance Policy Regarding Change of Beneficiary, 44 POF3d 377.

CHAPTER 27

GROUP LIFE INSURANCE

Sec.

33-27-1. Group requirements generally.

Sec.

33-27-3. Required policy provisions.

RESEARCH REFERENCES

Am. Jur. Proof of Facts. — Decedent's Intent to Change Beneficiary of Life Insurance Policy, 1 POF2d 437.

Fraudulent Cancellation of Life Insurance, 5 POF2d 587.

Innocent Misrepresentation of Physical Condition by Applicant for Life or Health Insurance, 23 POF2d 53.

Materiality of Applicant's Misrepresentation in Application for Life or Health Insurance, 3 POF3d 367.

Litigating the Suicide Exclusion in Life Insurance Policies, 20 POF3d 705.

Insurer's Liability for Improper Issuance or Maintenance of Life Insurance Policy, Prompting Murder or Attempted Murder of Insured, 37 POF3d 149.

Substantial Compliance with Requirements of Life Insurance Policy Regarding Change of Beneficiary, 44 POF3d 377.

33-27-1. Group requirements generally.

No policy of group life insurance shall be delivered in this state unless it conforms to one of the following descriptions:

(1) **Employee groups.** A policy issued to an employer or to the trustees of a fund established by an employer, which employer or trustee shall be deemed the policyholder, to insure employees of the

employer for the benefit of persons other than the employer, subject to the following requirements:

(A) The employees eligible for insurance under the policy shall be all of the employees of the employer or all of any class or classes thereof determined by conditions pertaining to their employment. The policy may provide that the term "employees" shall include the employees of one or more subsidiary corporations and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietors, or partnerships, if the business of the employer and of such affiliated corporations, proprietors, or partnerships is under common control through stock ownership or contract or otherwise. The policy may provide that the term "employees" shall include the individual proprietor or partners if the employer is an individual proprietor or a partnership. The policy may provide that the term "employees" shall include retired employees. No individual proprietor or partner shall be eligible for insurance under the policy unless he is actively engaged in and devotes a substantial part of his time to the conduct of the business of the proprietor or partnership. A policy issued to insure the employees of a public body may provide that the term "employees" shall include elected or appointed officials;

(B) The premium for the policy shall be paid by the policyholder either from the employer's own funds or from charges collected from the insured employee specifically for such insurance or from funds contributed by both the employer and the employee. A policy in which no part of the premium is to be derived from funds contributed by the insured employee must insure each eligible employee, except for any employee as to whom evidence of individual insurability is not satisfactory to the insurer;

(C) The policy must cover at least two employees at date of issue; and

(D) The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the employees or by the employer or trustee.

(2) **Debtor groups.** A policy issued to a creditor or to a trustee or agent appointed by two or more creditors, which creditor, trustee, or agent shall be deemed the policyholder, to insure debtors of the creditor, subject to the following requirements:

(A) The debtors eligible for insurance under the policy shall be all of the debtors of the creditor whose indebtedness is repayable either in installments, including any extraordinary payment of an installment or lease-purchase obligation, or in one sum at the end of a period not in excess of 24 months from the initial date of debt

or all of any class or classes thereof determined by conditions pertaining to the indebtedness or to the purchase giving rise to the indebtedness. The policy may provide that the term "debtors" shall include the debtors of one or more subsidiary corporations and the debtors of one or more affiliated corporations, proprietors, or partnerships, if the business of the policyholder and of such affiliated corporations, proprietors, or partnerships is under common control through stock ownership, contract, or otherwise. No debtor shall be eligible unless the indebtedness constitutes an irrevocable obligation to repay which is binding upon him during his lifetime at the time the insurance becomes effective upon his life;

(B) The premium for the policy shall be paid by the policyholder either from the creditor's funds, from charges collected from the insured debtors, or from both. A policy on which part or all of the premium is to be derived from the collection from the insured debtors of identifiable charges not required of uninsured debtors shall not include, in the class or classes of debtors eligible for insurance, debtors under obligations outstanding at its date of issue without evidence of individual insurability unless at least 75 percent of the then eligible debtors elect to pay the required charges. A policy on which no part of the premium is to be derived from the collection of such identifiable charges must insure all eligible debtors or all except any as to whom evidence of individual insurability is not satisfactory to the insurer;

(C) The policy may be issued only if the policy reserves to the insurer the right to require evidence of individual insurability if less than 75 percent of the new entrants become insured. The policy may exclude from the classes eligible for insurance classes of debtors determined by age;

(D) The amount of insurance on the life of any debtor shall at no time exceed the amount owed by him which is repayable in installments, the amount of the unpaid indebtedness, or \$75,000.00, whichever is less. Where the indebtedness is repayable in one sum to the creditor, the insurance on the life of any debtor shall in no instance be in effect for a period in excess of 24 months, except that such insurance may be continued for an additional period not exceeding six months in the case of default, extension, or recasting of the loan; and

(E) The insurance shall be payable to the policyholder. Such payment shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of such payment.

(3) **Mortgagee group.** A policy issued to a creditor, or to a trustee or agent appointed by two or more creditors, which creditor, trustee,

or agent shall be deemed the policyholder, to insure mortgagors of the creditor. The insurance must be written in connection with a credit transaction that is secured by a first mortgage or deed of trust; made to finance the purchase of real property or the construction of a dwelling thereon, or to refinance a prior credit transaction made for the purpose; and shall be payable to the policyholder. Such payment shall reduce or extinguish the unpaid mortgage of the mortgagor to the extent of such payment.

(4) **Agricultural loans.** Notwithstanding the provisions of this Code section, group life insurance in connection with agricultural loans may be written up to the amount of the loan or loan commitment on the nondecreasing or level term plan; however, the amount of insurance on the life of any such debtor shall not on any anniversary date of the insurance exceed the amount then owed by him which is repayable in installments, the amount of the then unpaid indebtedness, or \$75,000.00, whichever is less.

(5) **Labor union groups.** A policy issued to a labor union, which shall be deemed the policyholder, to insure members of such union for the benefit of persons other than the union or any of its officials, representatives, or agents, subject to the following requirements:

(A) The members eligible for insurance under the policy shall be all of the members of the union or all of any class or classes thereof determined by conditions pertaining to their employment or to membership in the union, or both;

(B) The premium for the policy shall be paid by the policyholder either wholly from the union's funds or partly from such funds and partly from funds contributed by the insured members specifically for their insurance. No policy may be issued on which the entire premium is to be derived from funds contributed by the insured members specifically for their insurance. A policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members or all except any as to whom evidence of individual insurability is not satisfactory to the insurer;

(C) The policy must cover at least 25 members at date of issue; and

(D) The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the members or by the union.

(6) **Trustee groups.** A policy issued to the trustees of a fund established by two or more employers or by one or more labor unions or by one or more employers and one or more labor unions, which

trustees shall be deemed the policyholder, to insure employees of the employers or members of the unions for the benefit of persons other than the employers or the unions, subject to the following requirements:

(A) The persons eligible for insurance shall be all of the employees of the employers, all of the members of the unions, or all of any class or classes of employees or union members determined by conditions pertaining to their employment, to membership in the unions, or to both. The policy may provide that the term "employees" shall include retired employees and the individual proprietor or partners if an employer is an individual proprietor or a partnership. No director of a corporate employer shall be eligible for insurance under the policy unless such person is otherwise eligible as a bona fide employee of the corporation by performing services other than the usual duties of a director. No individual proprietor or partner shall be eligible for insurance under the policy unless he is actively engaged in and devotes a substantial part of his time to the conduct of the business of the proprietor or partnership. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship;

(B) The premium for the policy shall be paid by the trustees wholly from funds contributed by the employer or employers of the insured persons, by the union or unions, or by both or partly from such funds and partly from funds contributed by the insured persons. No policy may be issued on which the entire premium is to be derived from funds contributed by the insured persons specifically for their insurance. A policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons or all except any as to whom evidence of individual insurability is not satisfactory to the insurer;

(C) The policy must cover at date of issue at least 100 persons; and, if the fund is established by the members of an association of employers, the policy may be issued only if either the participating employers constitute at date of issue at least 60 percent of those employer members whose employees are not already covered for group life insurance or the total number of persons covered at date of issue exceeds 600; and the policy shall not require that, if a participating employer discontinues membership in the association, the insurance of his employees shall cease solely by reason of the discontinuance; and

(D) The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the insured persons or by the policyholder, employers, or unions.

(7) **Association groups.** The lives of a group of individuals may be insured under a policy issued to an association, which shall be deemed the policyholder, to insure members of such association for the benefit of persons other than the association. As used in this paragraph, the term “association” means an association of governmental or public employees, an association of employees of a common employer, or an organization formed and operated in good faith for purposes other than that of procuring insurance and composed of members engaged in a common trade, business, or profession. The policy shall be subject to the following requirements:

(A) The members eligible for insurance under the policy shall be all of the members of the association or all of any class or classes of the association determined by conditions pertaining to their employment, to their trade, business, or profession, to their membership in the association, or to any two or more of such conditions. The policy may provide that officers and employees of the association who are bona fide members may be insured under the policy;

(B) The policy must cover at least 25 members at date of issue;

(C) The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the association or by the members; and

(D) The premium for the policy shall be paid by the policyholder either from the association’s own funds, or from charges collected from the insured members specifically for the insurance, or from both.

(8) **Bank and credit union groups.** A bank authorized to do business in this state may carry insurance upon its depositors for amounts not to exceed the savings deposit balances of each depositor or \$5,000.00, whichever is less, and a credit union organized pursuant to the laws of this state or the Federal Credit Union Act may carry insurance upon its members for amounts not to exceed the share and deposit balances of each member or \$5,000.00, whichever is less. Such insurance shall be subject to the requirements of subparagraphs (A) through (D) of paragraph (7) of this Code section.

(9) **Multiple employer welfare arrangements.**

(A) The lives of a group of individuals may be insured under a policy issued to a legal entity providing a multiple employer welfare arrangement. As used in this paragraph, the term “multiple employer welfare arrangement” means any employee benefit plan which is established or maintained for the purpose of offering or providing life insurance benefits to the employees of two or more employers, including self-employed individuals and their depen-

dents. The term does not apply to any plan or arrangement which is established or maintained by a tax-exempt rural electric cooperative or a collective bargaining agreement.

(B) The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the employees, employers, or trustee.

(10) **Special employee groups.** An entity or a trustee of a trust established by an entity which has an insurable interest in employees pursuant to subsection (d) of Code Section 33-24-3 and authority to effectuate insurance on employees pursuant to paragraph (4) or (5) of subsection (a) of Code Section 33-24-6 may establish an employee group to effectuate group life insurance policies on employees when such corporation or trustee of a trust is providing life, health, disability, retirement, or similar benefits to employees, provided that the premium for such group policies is wholly paid by the corporation or trustee of the trust and the proceeds of such policies are used to provide supplemental funding for such employee benefit plans. (Code 1933, § 56-2701, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1981, p. 1814, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1983, p. 464, §§ 1, 2; Ga. L. 1985, p. 616, § 1; Ga. L. 1987, p. 1333, § 1; Ga. L. 1987, p. 1486, §§ 1-5; Ga. L. 1989, p. 883, § 1; Ga. L. 1990, p. 8, § 33; Ga. L. 1990, p. 1402, § 1; Ga. L. 1993, p. 1721, § 5; Ga. L. 1994, p. 97, § 33; Ga. L. 1998, p. 768, § 1; Ga. L. 2005, p. 481, § 4/HB 291; Ga. L. 2006, p. 869, § 3/HB 1484.)

The 2006 amendment, effective July 1, 2006, substituted "An entity or a trustee of a trust established by an entity which has an insurable interest in employees pursuant to subsection (d)" for "A

corporation or a trustee of a trust established by a corporation which has an insurable interest in employees pursuant to subsection (c)" at the beginning of paragraph (10).

RESEARCH REFERENCES

Am. Jur. Pleading and Practice Forms. — 14A Am. Jur. Pleading and Practice Forms, Insurance, § 275.

33-27-3. Required policy provisions.

(a) No policy of group insurance shall be delivered in this state unless it contains in substance the following provisions or provisions which in the opinion of the Commissioner are more favorable to the persons insured or at least as favorable to the persons insured and more favorable to the policyholder:

(1) A provision that the policyholder is entitled to a grace period of not less than 31 days for the payment of any premium due except the first, during which grace period the death benefit coverage shall

continue in force, unless the policyholder shall have given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during such grace period;

(2) A provision that the validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue and that no statement made by any person insured under the policy relating to his or her insurability shall be used in contesting the validity of the insurance, with respect to which the statement was made, after the insurance has been in force prior to the contest for a period of two years during such person's lifetime nor unless it is contained in a written instrument signed by him or her;

(3) A provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued, that all statements made by the policyholder or by the persons insured shall be deemed representations and not warranties, and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the person or to his or her beneficiary;

(4) A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of his or her coverage;

(5) A provision specifying an equitable adjustment of premiums or of benefits or of both to be made in the event the age of a person insured has been misstated, such provision to contain a clear statement of the method of adjustment to be used;

(6) A provision that any sum becoming due by reason of the death of the person insured shall be payable to the beneficiary designated by the person insured, except as otherwise provided in paragraph (11) of this subsection, subject to the provisions of the policy, in the event there is no designated beneficiary living at the death of the person insured, as to all or any part of such sum and subject to any right reserved by the insurer in the policy and set forth in the certificate to pay at its option a part of such sum not exceeding \$500.00 to any person appearing to the insurer to be entitled equitably thereto by reason of having incurred funeral or other expenses incident to the last illness or death of the person insured;

(7) A provision that the insurer will issue to the policyholder for delivery to each person insured an individual certificate setting forth

a statement as to the insurance protection to which he or she is entitled, the person to whom the insurance benefits are payable, and the rights and conditions set forth in paragraphs (8) through (10) of this subsection;

(8) A provision that, if the insurance or any portion of it on a person covered under the policy other than the child of an employee insured pursuant to Code Section 33-27-2 ceases because of termination of employment or of membership in the class or classes eligible for coverage under the policy, the person shall be entitled to have issued to him or her by the insurer without evidence of insurability an individual policy of life insurance without disability or other supplementary benefits. Application for the individual policy shall be made and the first premium paid to the insurer within 31 days after termination of employment or of membership in the class or classes eligible for coverage under the policy. The individual policy shall at the option of the person be on any one of the forms, except term insurance, then customarily issued by the insurer at the age and for the amount applied for. The individual policy shall be in an amount not in excess of the amount of life insurance which ceases because of the termination, less the amount of any life insurance for which such person is or becomes eligible within 31 days after termination under the same or any other group policy, provided that any amount of insurance which shall have matured on or before the date of the termination as an endowment payable to the person insured, whether in one sum or in installments or in the form of an annuity, shall not for the purposes of this paragraph be included in the amount which is considered to cease because of such termination. The premium on the individual policy shall be at the insurer's then customary rate applicable to the form and amount of the individual policy, to the class of risk to which such person then belongs, and to his or her age attained on the effective date of the individual policy;

(9) A provision that, if the group policy terminates or is amended so as to terminate the insurance of any class of insured persons, every person insured under the group policy at the date of such termination, other than a child of an employee insured pursuant to Code Section 33-27-2, whose insurance terminates and who has been so insured for at least five years prior to such termination date shall be entitled to have issued to him or her by the insurer an individual policy of life insurance, subject to the same conditions and limitations as are provided by paragraph (8) of this subsection, except that the group policy may provide that the amount of such individual policy shall not exceed the smaller of the amount of the person's life insurance protection ceasing because of the termination or amendment of the group policy, less the amount of any life insurance for which he or she is or becomes eligible under any group policy issued

or reinstated by the same or another insurer within 31 days after such termination, and \$2,000.00;

(10) A provision that, if a person insured under the group policy dies during the period within which he or she would have been entitled to have an individual policy issued to him or her in accordance with paragraph (8) or (9) of this subsection, before such an individual policy shall have become effective, the amount of life insurance which he or she would have been entitled to have issued to him or her under such individual policy shall be payable as a claim under the group policy, whether or not application for the individual policy or the payment of the first premium therefor has been made; and

(11) An entity or trustee of a trust having an insurable interest pursuant to subsection (d) of Code Section 33-24-3 and effectuation authority pursuant to paragraph (4) or (5) of subsection (a) of Code Section 33-24-6, providing life, health, disability, retirement, or similar benefits to employees may designate the beneficiary of a group life insurance policy, provided that the corporation or trustee of a trust uses the insurance proceeds to provide life, health, disability, retirement, or similar benefits to such employees. As used in this paragraph, the term "employees" shall include directors, officers, employees, retired employees, or the dependents of such persons. The term "employee" shall include any former employee, but only for the purpose of replacing existing life insurance that will be surrendered in exchange for new life insurance in an amount not exceeding the insurance being surrendered.

(b)(1) The provisions of paragraphs (6), (8), (9), and (10) of subsection (a) of this Code section shall not apply to policies issued to a creditor to insure debtors or mortgagors of such creditor.

(2) The standard provisions required for individual life insurance policies shall not apply to group insurance policies.

(3) If the group life insurance policy is on a plan of insurance other than the term plan, it shall contain a nonforfeiture provision or provisions which in the opinion of the Commissioner is or are equitable to the insured persons and to the policyholder, but nothing in this Code section shall be construed to require that group life insurance policies contain the same nonforfeiture provisions as are required for individual life insurance policies.

(4) The provisions of paragraphs (6), (7), (8), (9), and (10) of subsection (a) of this Code section shall not apply to policies issued to a corporation or trustee of a trust pursuant to paragraph (9) of Code Section 33-27-1. (Code 1933, § 56-2704, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1983, p. 3, § 24; Ga. L. 1985,

p. 149, § 33; Ga. L. 1993, p. 1721, §§ 6, 7; Ga. L. 1995, p. 776, § 4; Ga. L. 2005, p. 481, § 5/HB 291; Ga. L. 2006, p. 869, § 4/HB 1484.)

The 2006 amendment, effective July 1, 2006, near the beginning of paragraph (a)(11), substituted “An entity” for “A cor-

poration”, substituted “subsection (d)” for “subsection (c)”, and substituted “provided” for “providing”.

CHAPTER 28

ANNUITY AND PURE ENDOWMENT CONTRACTS

Sec.
33-28-7. Proceeds of annuity, reversionary annuity, or pure endowment contracts not liable to at-

tachment, garnishment, or legal process in favor of creditors of beneficiary.

33-28-1. Definitions.

RESEARCH REFERENCES

Am. Jur. Pleading and Practice Forms. — 1C Am. Jur. Pleading and Practice Forms, Annuities, § 2.

33-28-7. Proceeds of annuity, reversionary annuity, or pure endowment contracts not liable to attachment, garnishment, or legal process in favor of creditors of beneficiary.

The proceeds of annuity, reversionary annuity, or pure endowment contracts issued to citizens or residents of this state, upon whatever form, shall not in any case be liable to attachment, garnishment, or legal process in favor of any creditor of the person who is the beneficiary of such annuity contract unless the annuity contract was assigned to or was effected for the benefit of such creditor or unless the purchase, sale, or transfer of the policy is made with the intent to defraud creditors. (Code 1933, § 56-2603, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2006, p. 885, § 2/HB 1304.)

The 2006 amendment, effective May 5, 2006, rewrote this Code section.

JUDICIAL DECISIONS

Bankruptcy. — There is no indication that the Georgia General Assembly intended to amend or supplement the bank-

ruptcy specific exemptions found in O.C.G.A. § 44-13-100 by way of the more general Georgia Insurance Code provi-

sions. Rather, it appears that the General Assembly intended the Georgia Insurance Code to apply to nonbankruptcy situations with the bankruptcy specific exemptions in § 44-13-100 applying in bankruptcy cases. In re Allen, No. JPS, 2010 Bankr. LEXIS 3563 (Bankr. M.D. Ga. Oct. 4, 2010).
Cited in Silliman v. Cassell (In re Cassell), 443 B.R. 200 (Bankr. N.D. Ga. 2010).

CHAPTER 29

INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE

Sec.	Sec.
33-29-3.2. Coverage for mammograms, Pap smears, and prostate specific antigen tests.	concerning renewability of individual accident and sickness policies; rules and regulations.
33-29-9. Requirements as to references in policies to noncancelable nature or guaranteed renewability nature; exception for certain matters	33-29-21.1. Availability of accident and sickness policy upon termination of dependent coverage based on age of dependent.

RESEARCH REFERENCES

Am. Jur. Proof of Facts. — Accidental Death — Food Asphyxiation, 2 POF2d 49. Business Travel Insurance, 17 POF3d 489.

33-29-3.2. Coverage for mammograms, Pap smears, and prostate specific antigen tests.

- (a) As used in this Code section, the term:
- (1) “Female at risk” means a woman:
 - (A) Who has a personal history of breast cancer;
 - (B) Who has a personal history of biopsy proven benign breast disease;
 - (C) Whose grandmother, mother, sister, or daughter has had breast cancer; or
 - (D) Who has not given birth prior to age 30.
 - (2) “Mammogram” means any low-dose radiologic screening procedure for the early detection of breast cancer provided to a woman and which utilizes equipment approved by the Department of Community Health dedicated specifically for mammography and includes a physician’s interpretation of the results of the procedure or interpre-

tation by a radiologist experienced in mammograms in accordance with guidelines established by the American College of Radiology. Reimbursement for a mammogram authorized under this Code section shall be made only if the facility in which the mammogram was performed meets accreditation standards established by the American College of Radiology or equivalent standards established by this state. Policies subject to this Code section shall contain coverage for mammograms made with at least the following frequency:

(A) Once as a base-line mammogram for any female who is at least 35 but less than 40 years of age;

(B) Once every two years for any female who is at least 40 but less than 50 years of age;

(C) Once every year for any female who is at least 50 years of age; and

(D) When ordered by a physician for a female at risk.

(3) "Pap smear" or "Papanicolaou smear" means an examination, in accordance with standards established by the American College of Pathologists, of the tissues of the cervix of the uterus for the purpose of detecting cancer when performed upon the order of a physician, which examination may be made once a year or more often if ordered by a physician.

(4) "Policy" means any benefit plan, contract, or policy except a disability income policy, specified disease policy, or hospital indemnity policy.

(5) "Prostate specific antigen test" means a measurement, in accordance with standards established by the American College of Pathologists, of a substance produced by the epithelium to determine if there is any benign or malignant prostate tissue.

(b)(1) Every insurer authorized to issue an individual accident and sickness insurance policy in this state which includes coverage for any female shall include as part of or as a required endorsement to each such policy which is issued, delivered, issued for delivery, or renewed on or after July 1, 1992, coverage for mammograms and Pap smears for the covered females which at least meets the minimum requirements of this Code section.

(2) Every insurer authorized to issue an individual accident and sickness insurance policy in this state which includes coverage for any male shall include as a part of or as a required endorsement to each such policy which is issued, delivered, issued for delivery, or renewed on or after July 1, 1992, coverage for annual prostate specific

antigen tests for the covered males who are 45 years of age or older, or for covered males who are 40 years of age or older, if ordered by a physician.

(c) The coverage required under subsection (b) of this Code section may be subject to such exclusions, reductions, or other limitations as to coverages, deductibles, or coinsurance provisions as may be approved by the Commissioner.

(d) Nothing in this Code section shall be construed to prohibit the issuance of individual accident and sickness insurance policies which provide benefits greater than those required by subsection (b) of this Code section or more favorable to the insured than those required by subsection (b) of this Code section.

(e) The provisions of this Code section shall apply to individual accident and sickness insurance policies issued by a fraternal benefit society, a nonprofit hospital service corporation, a nonprofit medical service corporation, a health care plan, a health maintenance organization, or any similar entity.

(f) Nothing contained in this Code section shall be deemed to prohibit the payment of different levels of benefits or from having differences in coinsurance percentages applicable to benefit levels for services provided by preferred and nonpreferred providers as otherwise authorized under the provisions of Article 2 of Chapter 30 of this title, relating to preferred provider arrangements. (Code 1981, § 33-29-3.2, enacted by Ga. L. 1990, p. 1057, § 1; Ga. L. 1992, p. 1975, § 1; Ga. L. 2009, p. 453, § 1-4/HB 228.)

The 2009 amendment, effective July 1, 2009, substituted “Department of Community Health” for “Department of Hu-

man Resources” in the first sentence of the introductory language of paragraph (a)(2).

33-29-9. Requirements as to references in policies to noncancelable nature or guaranteed renewability nature; exception for certain matters concerning renewability of individual accident and sickness policies; rules and regulations.

(a) No policy of accident or sickness insurance shall refer to its noncancelable nature without at the same time disclosing all options the insurer may have in regard to renewability; and the guaranteed renewable nature of any such policy shall not be referred to unless the reference at the same time discloses the qualifications on the guarantee of renewability, including any age limits, any right to change premium rates by class, any aggregate provisions, and any other limitations on the right to renewal in a manner which shall not minimize or render obscure the qualifying conditions.

(b) An insurer operating in the major medical or comprehensive, guaranteed renewable business in the State of Georgia shall permit an insured to change his or her major medical or comprehensive coverage, upon election at any renewal, to a comparable product currently offered by that insurer or a product currently offered by that insurer with more limited product benefits; to a product with higher deductibles; or to modify his or her existing coverage to elect any optional higher deductibles under that policy. If such product, benefit, or deductible change is elected by the insured during the 60 day required period after notice of renewal premium increase but before renewal date, such insured shall not be subject to any new preexisting conditions exclusion that did not apply to his or her original coverage.

(c) The Commissioner shall adopt such rules and regulations as he or she deems necessary for the administration of this Code section. (Code 1933, § 56-3010, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2006, p. 183, § 1/HB 1456.)

The 2006 amendment, effective July 1, 2006, designated the previously existing provisions of this Code section as subsection (a); and added subsections (b) and (c).

33-29-21.1. Availability of accident and sickness policy upon termination of dependent coverage based on age of dependent.

Every policy which contains a provision for termination of coverage of a dependent upon the reaching of a certain age shall contain a provision to the effect that, upon the date of the dependent reaching the age at which coverage would terminate under the provisions of the policy, the dependent shall be entitled to have issued to him or her, without evidence of insurability, upon application made to the company within 45 days following the date the dependent reaches the age at which coverage would terminate and upon the payment of the appropriate premium, an individual or family policy of accident and sickness insurance then being issued by the insurer which provides coverage most nearly similar to the coverage contained in the policy which was terminated by reason of dependent reaching a certain age or any similar individual or family policy then being issued by the insurer which contains lesser coverage. Any and all probationary or waiting periods set forth in such an individual or family policy shall be considered as being met to the extent coverage was in force under the prior policy. (Code 1981, § 33-29-21.1, enacted by Ga. L. 2006, p. 183, § 2/HB 1456.)

Effective date. — This Code section became effective July 1, 2006.

CHAPTER 29A

INDIVIDUAL HEALTH INSURANCE COVERAGE

Article 3

Individual Accident and Sickness Insurance

- Sec.

33-29A-30. Legislative findings and purpose; increasing availability of health insurance for uninsured individuals.

33-29A-31. Definitions.

33-29A-32. Commissioner to authorize insurers to offer individual accident and sickness insurance policies in Georgia that have been approved for issuance in other states.
- Sec.

33-29A-33. Satisfaction of actuarial standards set by National Association of Insurance Commissioners (NAIC); policies must comply with regulations and requirements promulgated by Commissioner; authority of Commissioner.

33-29A-34. Certain language required in policies and policy applications.

33-29A-35. Adoption of rules and regulations by Commissioner; application of dispute resolution mechanism or provision.

RESEARCH REFERENCES

- Am. Jur. Proof of Facts.** — Innocent Misrepresentation of Physical Condition by Applicant for Life or Health Insurance, 23 POF2d 53.

Materiality of Applicant’s Misrepresentation in Application for Life or Health Insurance, 3 POF3d 367.
- Use of Federal Estoppel Doctrine to Establish Coverage Under Group Health Insurance Policy, 43 POF3d 261.

ARTICLE 3

INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE

- Effective date.** — This article became effective July 1, 2011.

Law reviews. — For article on the
- 2011 enactment of this article, 28 Ga. St. U. L. Rev. 35 (2011).

33-29A-30. Legislative findings and purpose; increasing availability of health insurance for uninsured individuals.

The General Assembly recognizes the high level of uninsured individuals in this state and the need for individuals or other purchasers of health insurance coverage in this state to have the opportunity to choose health insurance plans that are more affordable and flexible than existing market policies offering accident and sickness insurance coverage. Therefore, the General Assembly seeks to increase the availability of health insurance coverage by allowing insurers authorized to transact insurance in Georgia to issue individual accident and sickness policies in Georgia that are currently approved for issuance in

another state. (Code 1981, § 33-29A-30, enacted by Ga. L. 2011, p. 789, § 1/HB 47; Ga. L. 2012, p. 775, § 33/HB 942.)

The 2012 amendment, effective May 1, 2012, part of an Act to revise, modernize, and correct the Code, substituted “pol-
 icies in Georgia that are currently ap-
 proved” for “policies in Georgia that is
 currently approved” in this Code section.

33-29A-31. Definitions.

For purposes of this article, the term “individual accident and sickness insurance policy” means any policy insuring against loss resulting from sickness or from bodily injury or death by accident, or both, or any contract to furnish ambulance service in the future but does not include limited benefit insurance policies exempted from the definition of the term “health benefit policy” in paragraph (1.1) of Code Section 33-1-2. The term “individual accident and sickness insurance policy” shall also include comprehensive major medical coverage for medical and surgical benefits, and also includes “High Deductible Health Plans” sold or maintained under the applicable provisions of Section 223 of the Internal Revenue Code. (Code 1981, § 33-29A-31, enacted by Ga. L. 2011, p. 789, § 1/HB 47.)

33-29A-32. Commissioner to authorize insurers to offer individual accident and sickness insurance policies in Georgia that have been approved for issuance in other states.

The Commissioner shall approve for sale in Georgia any individual accident and sickness insurance policy that is currently approved for issuance in another state where the insurer or the insurer’s affiliate or subsidiary is authorized to transact insurance so long as the insurer or the insurer’s affiliate or subsidiary filing and issuance such policy in Georgia is also authorized to transact insurance in this state pursuant to Chapter 3 of this title and provided that any such policy meets the requirements set forth in this article. Additionally, any insurer authorized to transact insurance in this state can offer an individual accident and sickness insurance policy with benefits equivalent to those in any policy approved for sale in Georgia under this article, provided that any such offered policy meets the requirements set forth in this article. (Code 1981, § 33-29A-32, enacted by Ga. L. 2011, p. 789, § 1/HB 47.)

33-29A-33. Satisfaction of actuarial standards set by National Association of Insurance Commissioners (NAIC); policies must comply with regulations and requirements promulgated by Commissioner; authority of Commissioner.

(a) Any insurer selling an insurance policy pursuant to this article, and any policy approved pursuant to this article, shall satisfy actuarial standards set forth by the National Association of Insurance Commissioners (NAIC) and any regulation promulgated by the Commissioner that is not inconsistent with such NAIC standards. Any insurer selling an insurance policy pursuant to this article, and any policy approved pursuant to this article, shall, except as otherwise provided in this article, comply with the requirements of this title and the regulations promulgated by the Commissioner.

(b) The Commissioner shall have the authority to determine whether an insurer satisfies the standards required by this Code section and may not approve a plan that he or she finds lacks compliance with this Code section. The Commissioner shall have the authority to determine whether the plan sold pursuant to this article continues to satisfy the requirements set forth in this Code section in the same manner as he or she does with an individual accident and sickness insurance policy approved pursuant to another applicable chapter in this title.

(c) Any policy sold pursuant to this article shall comply with paragraph (3) of subsection (c) of Code Section 9-9-2 and shall not require the insured or his or her beneficiary to arbitrate disputes arising under the policy. (Code 1981, § 33-29A-33, enacted by Ga. L. 2011, p. 789, § 1/HB 47.)

33-29A-34. Certain language required in policies and policy applications.

(a) Each written application for a policy sold pursuant to this article shall contain the following language in boldface type at the beginning of the document:

“The benefits of this policy may primarily be governed by the laws of a state other than Georgia; therefore, all of the laws applicable to policies filed in this state may not apply to this policy. Any purchase of individual health insurance should be considered carefully since future medical conditions may make it impossible to qualify for another individual health insurance policy.”

(b) Each policy sold pursuant to this article shall contain the following language in boldface type at the beginning of the document:

“The benefits of this policy providing your coverage may be governed primarily by the laws of a state other than Georgia. The

benefits covered may be different from other policies you can purchase. Please consult your insurance agent or insurer to determine which health benefits are covered under this policy.”

(c) Each individual accident and sickness policy sold pursuant to this article shall contain a side-by-side chart that compares the definitions of each benefit covered by the policy that has been sold in the other state with the definitions of the benefits covered under current Georgia laws and regulations where the specified benefit is similarly termed but defined differently. (Code 1981, § 33-29A-34, enacted by Ga. L. 2011, p. 789, § 1/HB 47.)

33-29A-35. Adoption of rules and regulations by Commissioner; application of dispute resolution mechanism or provision.

(a) The Commissioner shall adopt rules and regulations necessary to implement this article, which shall include, but shall not be limited to, standard forms for the disclosure of benefits, and preserve the intent and effect of Code Sections 33-24-27, 33-24-27.1, and 33-24-59.12 and subsection (c) of Code Section 33-29-6.

(b) Any dispute resolution mechanism or provision for notice and hearing in this title shall apply to insurers issuing and delivering policies pursuant to this article. (Code 1981, § 33-29A-35, enacted by Ga. L. 2011, p. 789, § 1/HB 47; Ga. L. 2012, p. 775, § 33/HB 942.)

The 2012 amendment, effective May 1, 2012, part of an Act to revise, modernize, and correct the Code, substituted “Code Sections 33-24-27, 33-24-27.1, and

33-24-59.12 and subsection (c) of Code Section 33-29-6” for “Code Sections 33-24-27.1, 33-24-27, 31-24-59.12, and 33-29-6(c)” at the end of subsection (a).

CHAPTER 29B

HEALTH CARE COVERAGE FOR CHILDREN

Sec.	Sec.
33-29B-1. (Effective January 1, 2013 and repealed effective January 1, 2014) Health insurance coverage to children through child-only health policies.	sions of this chapter as condition of issuing coverage; open enrollment; provide for guaranteed-issue coverage regardless of health status; special enrollment periods for loss of coverage due to qualifying event.
33-29B-2. (Effective January 1, 2013 and repealed effective January 1, 2014) Definitions.	
33-29B-3. (Effective January 1, 2013 and repealed effective January 1, 2014) Insurers subject to provi-	33-29B-4. (Effective January 1, 2013 and repealed effective January 1, 2014) Application for child-only

Sec.

policy if loss of coverage results from primary subscriber dropping policy.

33-29B-5. (Effective January 1, 2013 and repealed effective January 1, 2014) Denial of coverage if other creditable coverage is available.

33-29B-6. (Effective January 1, 2013 and repealed effective January 1, 2014) Renewal of current coverage; notice requirements for enrollment opportunities.

Sec.

33-29B-7. (Effective January 1, 2013 and repealed effective January 1, 2014) Insurer to submit certain information to Commissioner.

33-29B-8. (Effective January 1, 2013 and repealed effective January 1, 2014) Commissioner to adopt rules to implement and administer this chapter; sunset provision.

Effective date. — This chapter becomes effective January 1, 2013.

33-29B-1. (Effective January 1, 2013 and repealed effective January 1, 2014) Health insurance coverage to children through child-only health policies.

(a) It is the intention of this chapter to restore access to creditable health care coverage for Georgia's children, and that in order to do so, it is important to bring insurance providers into the market to offer individual health insurance coverage to children through child-only policies.

(b) For the protection of the public, particularly children and families, and for the protection of insurers required by federal law to guarantee the issue of individual health policies to children who are less than 19 years of age without imposing any preexisting condition exclusions, it is the intent of the General Assembly to accomplish this goal by establishing that as a condition of issuing health insurance coverage in the individual market until January 1, 2014, insurers offer child-only policies during open enrollment periods specified by this chapter. (Code 1981, § 33-29B-1, enacted by Ga. L. 2012, p. 617, § 1/HB 1166.)

Editor's notes. — Ga. L. 2012, p. 617, Code section effective January 1, 2014. § 1/HB 1166 provides for the repeal of this See Code Section 33-29B-8.

33-29B-2. (Effective January 1, 2013 and repealed effective January 1, 2014) Definitions.

(a) As used in this chapter, the term:

(1) "Child-only policy" means individual health insurance coverage for a qualified individual who is less than 19 years of age. Such term

shall not include dependent health insurance for a qualified individual under another person's health insurance.

(2) "Creditable coverage" means medical expense coverage under any of the following:

(A) Medicare or Medicaid;

(B) An employer based accident and sickness insurance or health benefit arrangement;

(C) An individual accident and sickness insurance policy, including coverage issued by a health maintenance organization, non-profit hospital or nonprofit medical service corporation, health care corporation, or fraternal benefit society;

(D) A spouse's benefits or coverage under medicare or Medicaid or an employer based health insurance or health benefit arrangement;

(E) A conversion policy;

(F) A franchise policy issued on an individual basis to a member of a true association as defined in subsection (b) of Code Section 33-30-1;

(G) A health policy formed pursuant to 10 U.S.C. Chapter 55;

(H) A health policy provided through the Indian Health Service or a tribal organization program or both;

(I) A state health benefits risk pool;

(J) A health policy formed pursuant to 5 U.S.C. Chapter 89;

(K) A public health policy; or

(L) A Peace Corps Act health benefit policy.

(3) "Health insurance" has the same meaning as accident and sickness policy as defined in Code Section 33-29-1. Such term shall not include:

(A) Any policy of workers' compensation insurance or any policy of workers' insurance or any policy of liability insurance with or without supplementary expense coverage on the policy;

(B) Any policy or contract of reinsurance;

(C) Any policy, the renewal of which is subject to continuation of employment with a specified employer, any blanket or group policy of insurance, or any policy issued pursuant to the exercise of conversion privileges provided for in group insurance policies;

(D) Life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to accident and sickness insurance which provide additional benefits in case of death or dismemberment or loss of sight by accident, or which operate to safeguard such contracts against lapse or give a special surrender value or special benefit or an annuity in the event that the insured or annuitant becomes totally and permanently disabled as defined by the contract or supplemental contract;

(E) Companies, organizations, or associations provided for in Chapters 18 and 19 of this title; or

(F) Any policy of accident, sickness, or hospitalization insurance issued prior to January 1, 1961; long-term care, disability income, short-term, accident, dental-only, vision-only, fixed indemnity, limited-benefit, or credit insurance; coverage issued as a supplement to liability insurance; insurance arising out of workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(4) "Insurer" means an insurance company, insurance service, or insurance organization licensed to engage in the business of insurance in Georgia and which is subject to this title. Such term shall not include a group health policy.

(5) "Open enrollment period" means January 1, 2013, through January 31, 2013.

(6) "Qualified individual" means a resident of this state who is less than 19 years of age.

(7) "Qualifying event" means the loss of employer sponsored health insurance or the involuntary loss of other existing health insurance for any reason other than fraud, misrepresentation, or failure to pay a premium if the applicant is a qualified individual when the qualifying event occurs. (Code 1981, § 33-29B-2, enacted by Ga. L. 2012, p. 617, § 1/HB 1166.)

Editor's notes. — Ga. L. 2012, p. 617, § 1/HB 1166 provides for the repeal of this Code section effective January 1, 2014. See Code Section 33-29B-8.

33-29B-3. (Effective January 1, 2013 and repealed effective January 1, 2014) Insurers subject to provisions of this chapter as condition of issuing coverage; open enrollment; provide for guaranteed-issue coverage regardless of health status; special enrollment periods for loss of coverage due to qualifying event.

(a) All insurers that deliver or issue for delivery individual health insurance in this state shall be subject to the provisions of this chapter. As a condition of issuing coverage in the individual health market, an insurer shall ensure that at least one policy design issued pursuant to Code Section 33-29A-3 and this chapter shall be available to individuals applying for a child-only policy.

(b) Insurers shall offer guaranteed-issue coverage to primary subscribers under the age of 19 years during open enrollment periods during which insurers shall accept applications for child-only policies.

(c) During the open enrollment period set forth in subsection (b) of this Code section and within 30 days of a qualifying event, an insurer shall accept and grant an application to insure a qualified individual for a child-only policy on a guaranteed-issue basis without any limitations or exclusions of policy benefits based upon the applicant's health status pursuant to federal law.

(d) Insurers shall not offer child-only policies outside of the open enrollment period, except insurers shall permit a child under the age of 19 years to apply and enroll for coverage during a special enrollment period under the terms of the health benefit policy if the child has experienced a qualifying event.

(e) A special enrollment period shall last 30 days from the date the insurer receives notice of loss of coverage if:

(1) Such notice is provided to the insurer no later than the sixtieth day after the loss of coverage;

(2) The loss of other coverage results from:

(A) Birth;

(B) Adoption;

(C) Marriage;

(D) Dissolution of marriage;

(E) Loss of employer sponsored insurance;

(F) Loss of eligibility under Code Section 49-4-1 or 49-5-273;

(G) Entry of a valid court or administrative order mandating the child be covered; or

(H) Involuntary loss of other existing coverage for any reason other than fraud, misrepresentation, or failure to pay premium; or

(3) The person under 19 years of age is not eligible for creditable coverage.

(f) Coverage under individual policies applied for during the open enrollment period shall become effective within 30 days following the end of such period. Coverage under individual policies applied for during a special enrollment period shall become effective within 30 days following the end of the special enrollment period.

(g) Nothing in this Code section shall prohibit an insurer from setting a premium rate for individuals based upon medical underwriting so long as such rate is in compliance with the applicable product's rate filing on record with the department. An insurer may impose a surcharge for up to 12 months if an individual enrolls in a child-only policy without prior creditable coverage in the 63 day period preceding the date of application. The amount of the surcharge may be up to an additional 50 percent of the premium rate that would be charged if an individual enrolls in a child-only policy with prior creditable coverage in the 63 day period preceding the date of application. (Code 1981, § 33-29B-3, enacted by Ga. L. 2012, p. 617, § 1/HB 1166.)

Editor's notes. — Ga. L. 2012, p. 617, Code section effective January 1, 2014.
§ 1/HB 1166 provides for the repeal of this See Code Section 33-29B-8.

33-29B-4. (Effective January 1, 2013 and repealed effective January 1, 2014) Application for child-only policy if loss of coverage results from primary subscriber dropping policy.

In the event that an individual under the age of 19 years is a dependent on a policy with a primary subscriber who is over the age of 19 years and such primary subscriber drops the policy, all dependents shall lose coverage as a result of the termination of coverage of the primary subscriber. Such individuals under the age of 19 years may apply for child-only policies during the open enrollment period or, in the case of a qualifying event, during a special enrollment period. (Code 1981, § 33-29B-4, enacted by Ga. L. 2012, p. 617, § 1/HB 1166.)

Editor's notes. — Ga. L. 2012, p. 617, Code section effective January 1, 2014.
§ 1/HB 1166 provides for the repeal of this See Code Section 33-29B-8.

33-29B-5. (Effective January 1, 2013 and repealed effective January 1, 2014) Denial of coverage if other creditable coverage is available.

An insurance carrier may deny coverage to an applicant for enrollment in a child-only policy if other creditable coverage is available. For purposes of this Code section, the term “creditable coverage” shall not include eligibility for a high-risk pool insurance policy, but shall include current enrollment in a high-risk pool insurance policy. (Code 1981, § 33-29B-5, enacted by Ga. L. 2012, p. 617, § 1/HB 1166.)

Editor’s notes. — Ga. L. 2012, p. 617, Code section effective January 1, 2014. § 1/HB 1166 provides for the repeal of this See Code Section 33-29B-8.

33-29B-6. (Effective January 1, 2013 and repealed effective January 1, 2014) Renewal of current coverage; notice requirements for enrollment opportunities.

(a) Insurers currently covering subscribers or dependents under the age of 19 years on individual policies shall continue to renew such policies in accordance with Code Section 33-29-21.

(b) Notice of the open enrollment opportunity, open enrollment dates for new applicants, the opportunity to enroll due to a qualifying event, and instructions on how to enroll a child in a child-only policy shall be displayed continuously and prominently on the insurer’s website throughout the year. (Code 1981, § 33-29B-6, enacted by Ga. L. 2012, p. 617, § 1/HB 1166.)

Editor’s notes. — Ga. L. 2012, p. 617, Code section effective January 1, 2014. § 1/HB 1166 provides for the repeal of this See Code Section 33-29B-8.

33-29B-7. (Effective January 1, 2013 and repealed effective January 1, 2014) Insurer to submit certain information to Commissioner.

Each insurer that participates in the individual market in Georgia shall submit to the Commissioner the following information at the time the insurer submits the information pertaining to 2013 that is required in Code Section 33-3-21:

(1) The number of applicants for a child-only policy during open enrollment period;

(2) The number of individuals who enrolled in a child-only policy during the open enrollment period; and

(3) The number of applicants denied enrollment in a child-only policy during the open enrollment period and the reasons for the

denials. (Code 1981, § 33-29B-7, enacted by Ga. L. 2012, p. 617, § 1/HB 1166.)

Editor’s notes. — Ga. L. 2012, p. 617, Code section effective January 1, 2014. § 1/HB 1166 provides for the repeal of this See Code Section 33-29B-8.

33-29B-8. (Effective January 1, 2013 and repealed effective January 1, 2014) Commissioner to adopt rules to implement and administer this chapter; sunset provision.

(a) The Commissioner shall adopt rules to implement and administer this chapter.

(b) This chapter and the rules adopted by the Commissioner to administer this chapter shall stand repealed on January 1, 2014. (Code 1981, § 33-29B-8, enacted by Ga. L. 2012, p. 617, § 1/HB 1166.)

CHAPTER 30

GROUP OR BLANKET ACCIDENT AND SICKNESS INSURANCE

Article 1		Article 2	
General Provisions		Preferred Provider Arrangements	
Sec.		Sec.	
33-30-1.	“Group accident and sickness insurance” defined; “true association” defined.	33-30-24.	Health benefit plans providing incentives to use services of preferred providers; minimum requirements.
33-30-4.2.	Insurance coverage for mammograms, Pap smears, and prostate specific antigen tests.		

ARTICLE 1

GENERAL PROVISIONS

33-30-1. “Group accident and sickness insurance” defined; “true association” defined.

(a) “Group accident and sickness insurance” is that form of accident and sickness insurance covering the groups of persons listed in paragraphs (1) through (7) of this subsection, with or without one or more members of their families or one or more of their dependents or covering one or more members of the families or one or more dependents of persons in such groups, and issued upon the following basis:

(1) Under a policy issued to an employer or trustees of a fund established by an employer, who shall be deemed the policyholder,

insuring at least two employees of such employer for the benefit of persons other than the employer. As used in this paragraph, the term “employees” includes the officers, managers, and employees of the employer; the individual proprietor or partners, if the employer is an individual proprietor or partnership; the officers, managers, and employees of subsidiary or affiliated corporations; and the individual proprietors, partners, and employees of individuals and firms, if the business of the employer and such individual or firm is under common control through stock ownership, contract, or otherwise. The term may include retired employees. A policy issued to insure employees of a public body may provide that the term “employees” shall include elected or appointed officials;

(2) Under a policy issued to an association, including a labor union, which shall have a constitution and bylaws and which has been organized and is maintained in good faith for purposes other than that of obtaining insurance, insuring at least ten members, employees, or employees of members of the association for the benefit of persons other than the association or its officers or trustees. As used in this paragraph, the term “employees” may include retired employees;

(3) Under a policy issued to the trustees of a fund established by two or more employers in the same industry, by one or more labor unions, by one or more employers and one or more labor unions, or by an association, as defined in paragraph (2) of this subsection, which trustees shall be deemed the policyholder, to insure not less than ten employees of the employers or members of the union or of such association or of members of such association for the benefit of persons other than the employers or other unions or such associations. As used in this paragraph, the term “employees” includes the officers, managers, and employees of the employer and the individual proprietor or partners, if the employer is an individual proprietor or partnership. The term may include retired employees. The policy may provide that the term “employees” shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship;

(4) Under a policy issued to any person or organization to which a policy of group life insurance may be delivered in this state, to insure any class or classes of individuals that could be insured under such group life policy;

(5) Under a policy issued to a creditor, or to a trustee or agent appointed by two or more creditors, which creditor, trustee, or agent shall be deemed to be the policyholder, to insure mortgagors of the creditor. The insurance must be written in connection with a credit transaction that is secured by a first mortgage or deed of trust; must

be made to finance the purchase of real property or the construction of a dwelling thereon, or to refinance a prior credit transaction made for such a purpose; and shall be payable to the policyholder. Such payment shall reduce or extinguish the unpaid mortgage of the mortgagor to the extent of such payment;

(6) Under a policy issued to cover any other substantially similar group which in the discretion of the Commissioner may be subject to the issuance of a group accident and sickness policy or contract; or

(7)(A) Under a policy issued to a legal entity providing a multiple employer welfare arrangement, which means any employee benefit plan which is established or maintained for the purpose of offering or providing accident and sickness benefits to the employees of two or more employers, including self-employed individuals, individuals whose compensation is reported on federal Internal Revenue Service Form 1099, and their spouses or dependents. The term shall not apply to any plan or arrangement which is established or maintained by a tax-exempt rural electric cooperative or a collective bargaining agreement.

(B) The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the employees, employers, or trustee.

(b) As used in this chapter, the term “true association” means an organization that:

(1) Has been in existence for at least five years;

(2) Has been formed and maintained in good faith for purposes other than obtaining insurance;

(3) Does not condition membership in the association on any health status related factor relating to an individual (including an employee of an employer or a dependent of an employee);

(4) Makes health insurance coverage offered through the association available to all members regardless of any health status related factor relating to such members (or individual eligible for coverage through a member);

(5) Does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

(6) Meets such additional requirements as may be imposed under Georgia law or regulation. (Code 1933, § 56-3101, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1987, p. 1486, § 7; Ga. L. 1989, p. 883, § 2; Ga. L. 1990, p. 1402, § 4; Ga. L. 1991, p. 94, § 33; Ga. L. 1997, p. 1462, § 6; Ga. L. 1998, p. 1064, § 9; Ga. L. 2005,

p. 481, § 9/HB 291; Ga. L. 2011, p. 595, §§ 2, 3/HB 167; Ga. L. 2012, p. 775, § 33/HB 942.)

The 2011 amendment, effective July 1, 2011, substituted “ten members” for “25 members” in the first sentence of paragraph (a)(2); substituted “ten employees” for “25 employees” in the first sentence of paragraph (a)(3); and, in subparagraph (a)(7)(A), in the first sentence, inserted “individuals whose compensation is reported on federal Internal Revenue Service Form 1099”, and inserted “spouses or”, and substituted “term shall” for “term does” in the second sentence.

The 2012 amendment, effective May 1, 2012, part of an Act to revise, modernize, and correct the Code, substituted “paragraph (2) of this subsection” for “paragraph (2) of this Code section” in the first sentence of paragraph (a)(3).

Editor’s notes. — Ga. L. 2011, p. 595, § 1, not codified by the General Assembly, provides that: “This Act shall be known and may be cited as the ‘Insurance Delivery Enhancement Act of 2011.’”

RESEARCH REFERENCES

Am. Jur. Pleading and Practice Forms. — 14A Am. Jur. Pleading and Practice Forms, Insurance, § 275.

33-30-4.2. Insurance coverage for mammograms, Pap smears, and prostate specific antigen tests.

(a) As used in this Code section, the term:

(1) “Female at risk” means a woman:

(A) Who has a personal history of breast cancer;

(B) Who has a personal history of biopsy proven benign breast disease;

(C) Whose grandmother, mother, sister, or daughter has had breast cancer; or

(D) Who has not given birth prior to age 30.

(2) “Mammogram” means any low-dose radiologic screening procedure for the early detection of breast cancer provided to a woman and which utilizes equipment approved by the Department of Community Health dedicated specifically for mammography and includes a physician’s interpretation of the results of the procedure or interpretation by a radiologist experienced in mammograms in accordance with guidelines established by the American College of Radiology. Reimbursement for a mammogram authorized under this Code section shall be made only if the facility in which the mammogram was performed meets accreditation standards established by the American College of Radiology or equivalent standards established by this state. Policies subject to this Code section shall contain coverage for mammograms made with at least the following frequency:

(A) Once as a base-line mammogram for any female who is at least 35 but less than 40 years of age;

(B) Once every two years for any female who is at least 40 but less than 50 years of age;

(C) Once every year for any female who is at least 50 years of age; and

(D) When ordered by a physician for a female at risk.

(3) "Pap smear" or "Papanicolaou smear" means an examination, in accordance with standards established by the American College of Pathologists, of the tissues of the cervix of the uterus for the purpose of detecting cancer when performed upon the order of a physician, which examination may be made once a year or more often if ordered by a physician.

(4) "Policy" means any benefit plan, contract, or policy except a disability income policy, specified disease policy, or hospital indemnity policy.

(5) "Prostate specific antigen test" means a measurement, in accordance with standards established by the American College of Pathologists, of a substance produced by the epithelium to determine if there is any benign or malignant prostate tissue.

(b)(1) Every insurer authorized to issue a group accident and sickness insurance policy in this state which includes coverage for any female shall include as part of or as a required endorsement to each such policy which is issued, delivered, issued for delivery, or renewed on or after July 1, 1992, coverage for mammograms and Pap smears for the covered females which at least meets the minimum requirements of this Code section.

(2) Every insurer authorized to issue a group accident and sickness insurance policy in this state which includes coverage for any male shall include as a part of or as a required endorsement to each such policy which is issued, delivered, issued for delivery, or renewed on or after July 1, 1992, coverage for annual prostate specific antigen tests for the covered males who are 45 years of age or older or for covered males who are 40 years of age or older, if ordered by a physician.

(c) The coverage required under subsection (b) of this Code section may be subject to such exclusions, reductions, or other limitations as to coverages, deductibles, or coinsurance provisions as may be approved by the Commissioner.

(d) Nothing in this Code section shall be construed to prohibit the issuance of group accident and sickness insurance policies which

provide benefits greater than those required by subsection (b) of this Code section or more favorable to the insured than those required by subsection (b) of this Code section.

(e) The provisions of this Code section shall apply to group accident and sickness insurance policies issued by a fraternal benefit society, a nonprofit hospital service corporation, a nonprofit medical service corporation, a health care plan, a health maintenance organization, or any similar entity.

(f) Nothing contained in this Code section shall be deemed to prohibit the payment of different levels of benefits or from having differences in coinsurance percentages applicable to benefit levels for services provided by preferred and nonpreferred providers as otherwise authorized under the provisions of Article 2 of this chapter, relating to preferred provider arrangements. (Code 1981, § 33-30-4.2, enacted by Ga. L. 1990, p. 1057, § 2; Ga. L. 1992, p. 1975, § 2; Ga. L. 2009, p. 453, § 1-4/HB 228.)

The 2009 amendment, effective July 1, 2009, substituted “Department of Community Health” for “Department of Hu-

man Resources” in the first sentence of the introductory language of paragraph (a)(2).

33-30-12. Standards and requirements for rating of small groups under accident and sickness insurance; exemptions.

JUDICIAL DECISIONS

Private claims against insurer not subject to administrative exhaustion requirement. — As the Georgia Commissioner of Insurance had agreed with a small business that its health insurer had violated O.C.G.A. § 33-30-12 by using health status factors to calculate renewal premiums, the business was not aggrieved by an agency decision, and it was not required to pursue administrative remedies before filing its lawsuit against the insurer, alleging multiple claims arising from the insurer’s practice under state law; additionally, the business’s participation in a settlement with the insurer for such statutory violations did not preclude the action, as the Commissioner did not have exclusive or primary jurisdiction over such vested legal disputes. *Homes of Ga., Inc. v. Humana Empls. Health Plan of Ga., Inc.*, 282 Ga. App. 802, 640 S.E.2d 313 (2006).

No ERISA preemption. — Business

that commenced an action based on state law and common law claims against its health insurer, asserting that the insurer had improperly relied on health status factors in determining the renewal premium rate in violation of O.C.G.A. § 33-30-12, was not preempted by the Employee Retirement Security Act of 1974, 29 U.S.C. § 1001 et seq., as amended, as the claims were directed at the business’s health insurance contract rather than at the group health insurance plan. *Homes of Ga., Inc. v. Humana Empls. Health Plan of Ga., Inc.*, 282 Ga. App. 802, 640 S.E.2d 313 (2006).

Class action certification not an abuse of discretion. — In a suit brought by various insureds, alleging that an insurance company and the company’s related entities engaged in fraud with regard to allegedly fraudulently representing that they were being provided group medical insurance coverage, the trial

court did not abuse the court’s discretion by certifying the insureds as a class as the reliance of the insureds was based on a uniform renewal document all received, which satisfied the commonality requirement, and differing defenses that they may have did not defeat certification since common questions of law predominated.

The reviewing court was satisfied that the trial court exercised judicial discretion in ruling that the computation of individual damages would not be so complex or fact-specific so as to bar certification. *Fortis Ins. Co. v. Kahn*, 299 Ga. App. 319, 683 S.E.2d 4 (2009), cert. denied, No. S09C1992, 2010 Ga. LEXIS 48 (Ga. 2010).

ARTICLE 2

PREFERRED PROVIDER ARRANGEMENTS

33-30-20. Short title.

JUDICIAL DECISIONS

Cited in *Morrell v. Wellstar Health Sys., Inc.*, 280 Ga. App. 1, 633 S.E.2d 68 (2006); *Nat’l Renal Alliance, LLC v. Blue*

Cross & Blue Shield of Ga., Inc., 598 F. Supp. 2d 1344 (N.D. Ga. 2009).

33-30-21. Legislative intent.

JUDICIAL DECISIONS

Judicial intervention refused. — Appellate court refused to intervene in allegations made by uninsured patients against a non-profit hospital that they were charged more than patients who were covered by insurance, Medicare, or Medicaid, as it refused to intervene in a commercial transaction for which the leg-

islature has already established a policy favoring price-comparison by the patient, whereby judges and juries would be called on to set appropriate prices for hospitals to charge their patients. *Cox v. Athens Reg’l Med. Ctr., Inc.*, 279 Ga. App. 586, 631 S.E.2d 792 (2006).

33-30-23. Standards; payments or reimbursement for noncontracting provider of covered services; filing requirements for unlicensed entities; provision for payment solely to provider.

JUDICIAL DECISIONS

ERISA preemption. — When an insurer cut the insurer’s reimbursement for out-of-network renal dialysis by 88 percent to levels below customary charges, under 29 U.S.C. § 1144(a), state law claims filed by dialysis treatment providers—including claims for breach of contract, misrepresentation, unfair trade practices, quantum meruit, and those arising under O.C.G.A. § 33-30-23(a)(2) — were preempted because they related to

conduct intertwined with the refusal to pay benefits. *Nat’l Renal Alliance, LLC v. Blue Cross & Blue Shield of Ga., Inc.*, 598 F. Supp. 2d 1344 (N.D. Ga. 2009).

Judicial intervention refused. — Appellate court refused to intervene in allegations made by uninsured patients against a non-profit hospital that they were charged more than patients who were covered by insurance, Medicare, or Medicaid, as it refused to intervene in a

commercial transaction for which the legislature has already established a policy favoring price-comparison by the patient, whereby judges and juries would be called

on to set appropriate prices for hospitals to charge their patients. *Cox v. Athens Reg'l Med. Ctr., Inc.*, 279 Ga. App. 586, 631 S.E.2d 792 (2006).

33-30-24. Health benefit plans providing incentives to use services of preferred providers; minimum requirements.

Health care insurers may issue health benefit plans which provide for incentives for covered persons to use the health care services of preferred providers. Such policies or subscriber certificates shall contain at least the following provisions:

- (1) A provision that if a covered person receives emergency care for services specified in the preferred provider arrangement and cannot reasonably reach a preferred provider, that emergency care rendered during the course of the emergency will be paid for in accordance with the terms of the health benefit plan, at benefit levels at least equal to those applicable to treatment by preferred providers for emergency care in an amount based on the usual, customary, and reasonable charges in the area where the treatment is provided; and
- (2) A provision which clearly identifies the differences in benefit levels for health care services of preferred providers and benefit levels for health care services of nonpreferred providers.

For purposes of this Code section, when a request for emergency care is made through the emergency 9-1-1 system on behalf of a covered person and the ambulance service licensed under Chapter 11 of Title 31 that was dispatched in response to the request is not a preferred provider, for purposes of payment under paragraph (1) of this Code section, it shall be presumed that the covered person could not reasonably reach a preferred provider. (Code 1981, § 33-30-24, enacted by Ga. L. 1988, p. 1483, § 1; Ga. L. 2006, p. 652, § 5/HB 1257.)

The 2006 amendment, effective July 1, 2006 added the last undesignated paragraph.

CHAPTER 31

CREDIT LIFE INSURANCE AND CREDIT ACCIDENT
AND SICKNESS INSURANCE

33-31-1. Definitions.

JUDICIAL DECISIONS

Cited in *Flynt v. Life of the South Ins. Co.*, 312 Ga. App. 430, 718 S.E.2d 343 (2011).

33-31-5. Date insurance becomes effective; duration and termination of insurance.

JUDICIAL DECISIONS

Credit life insurer was required to refund unearned premiums despite policy provision requiring written notice. — Credit life insurer's failure to refund unearned premiums unless an insured provided written notice to the insurer constituted a breach of the legal duty the insurer owed to its insureds to refund unearned premiums under

O.C.G.A. § 33-31-5. The notice requirement in the policy was not a condition precedent or express stipulation of forfeiture, and failure to return unearned premiums was a breach of the insurer's obligation of good faith and fair dealing. *Res. Life Ins. Co. v. Buckner*, 304 Ga. App. 719, 698 S.E.2d 19 (2010).

33-31-9. Premiums; refunds and credits.

Law reviews. — For survey article on insurance law, see 59 Mercer L. Rev. 195 (2007). For survey article on trial practice and procedure, see 59 Mercer L. Rev. 423

(2007). For survey article on trial practice and procedure, see 60 Mercer L. Rev. 397 (2008).

JUDICIAL DECISIONS

Notice. — Insured's suit seeking a refund of unearned credit life insurance and credit disability policy premiums under O.C.G.A. § 33-31-9(c) was not barred by the insured's failure to give the insurer pre-suit notice of the insured's early payoff of the insured's truck loan; because O.C.G.A. § 33-31-9(c) did not specify a particular time for giving notice, the insured's filing of the complaint constituted sufficient notice. *Baker v. Am. Heritage Life Ins. Co.*, No. 4:05-CV-128(CDL), 2006 U.S. Dist. LEXIS 62586 (M.D. Ga. Sept. 1, 2006).

unearned premiums unless an insured provided written notice to the insurer constituted a breach of the legal duty the insurer owed to its insureds to refund unearned premiums under O.C.G.A. § 33-31-5. The notice requirement in the policy was not a condition precedent or express stipulation of forfeiture, and failure to return unearned premiums was a breach of the insurer's obligation of good faith and fair dealing. *Res. Life Ins. Co. v. Buckner*, 304 Ga. App. 719, 698 S.E.2d 19 (2010).

Notice requirement met. — Because an insurer expressly acknowledged that,

Credit life insurer's failure to refund

by filing suit, the insured satisfied any contractual notice requirement obligating the insurer to return any unearned premium, and a 2005 amendment to O.C.G.A. § 33-31-9 did not affect this result, the appeals court rejected the insurer's claim that the insured's claim in contract was barred due to the insured's failure to submit proof of early loan payoff, as required by both the expressed and implied terms of the insurance contract. *J.M.I.C. Life Ins. Co. v. Toole*, 280 Ga. App. 372, 634 S.E.2d 123 (2006).

Sufficiency of notice. — Insured's failure to provide pre-suit notice of an early loan payoff and an insurer's failure to refund unearned premiums on credit policies because there were no express or implied term in the insurance certificates requiring pre-suit notice and the filing of

the lawsuit sufficiently complied with notice required under O.C.G.A. § 33-31-9(c). *Bishop's Prop. & Invs., LLC v. Protective Life Ins. Co.*, No. 4:05-CV-126(CDL), 2006 U.S. Dist. LEXIS 62593 (M.D. Ga. Sept. 1, 2006).

Torts related to contract. — Appellate court rejected an insurer's assertion that its insured's individual tort claims failed because a tort was the unlawful violation of a private legal right other than a mere breach of contract, express or implied, as the duties the insured alleged that the insurer violated did not arise merely from contract but were also imposed by O.C.G.A. § 33-31-9. *J.M.I.C. Life Ins. Co. v. Toole*, 280 Ga. App. 372, 634 S.E.2d 123 (2006).

Cited in *SunTrust Bank v. Hightower*, 291 Ga. App. 62, 660 S.E.2d 745 (2008).

CHAPTER 32

PROPERTY INSURANCE

RESEARCH REFERENCES

Am. Jur. Proof of Facts. — Recovery Under Property Insurance for Loss Due to Surface Water, Sewer Backup, and Flood, 48 POF3d 419.

Loss by Storm Damage Under Property Insurance, 49 POF3d 501.

33-32-1. Standard fire policy.

JUDICIAL DECISIONS

One year time limit to file suit contained in policy enforceable. — In an insurer's declaratory judgment action involving the insurer's obligations under a parent's property insurance policy, the insurer was properly granted summary judgment as to a child's claim since that claim was filed past the one year time limit set forth in the policy, which was a policy renewed in 2004. The child's counterclaim was filed 18 months after the declaratory judgment suit was filed and no waiver of the one year time limit was

established. *Morrill v. Cotton States Mut. Ins. Co.*, 293 Ga. App. 259, 666 S.E.2d 582 (2008).

At least as favorable. — Parties' intent was that the policy's statute of limitations provision be amended to conform to the Standard Fire Policy two-year statute of limitations provision and the conformed policy language clearly complied with O.C.G.A. § 33-32-1(a)'s requirement that the policy be at least as favorable to the insured as the standard fire policy. *Jenkins v. Allstate Prop. & Cas. Ins. Co.*,

No. 11-11811, 2011 U.S. App. LEXIS 24655 (11th Cir. Dec. 13, 2011) (Unpublished).

RESEARCH REFERENCES

Am. Jur. Proof of Facts. — Fire Insurer's Bad Faith in Responding to Claim by Insured, 49 POF2d 1.

Arson Defense to Coverage Under Property Insurance, 34 POF3d 291.

CHAPTER 34

MOTOR VEHICLE ACCIDENT REPARATIONS

Sec.

33-34-5.1. Self-insurers.

RESEARCH REFERENCES

Am. Jur. Proof of Facts. — "Commercial" Use of an Automobile, 1 POF2d 285.

Insurer's Wrongful Refusal to Settle Within Policy Limits, 6 POF2d 247.

Resident of Household of Named Insured, 13 POF2d 681.

Automobile Insurer's Waiver of Policy Restriction, 27 POF2d 683.

Use of Motor Vehicle by Person Claiming Insurance Coverage, 34 POF2d 585.

Automobile Insurer's Bad Faith in Responding to First-Party Claim, 3 POF3d 751.

Ineffective Cancellation of Automobile Insurance Policy — Deficient Communication of Cancellation Notice, 10 POF3d 483.

Ineffective Cancellation of Automobile

Insurance Policy — Deficient Form or Content of Cancellation Notice, 11 POF3d 131.

Ineffective Cancellation of Automobile Insurance Policy — Deficient Repayment or Render of Unearned Premium, 11 POF3d 227.

"Permissive" Use of Automobile — Grant of Permission to Insured's Permittee, 16 POF3d 433.

"Permissive" Use of Automobile — Delegation of permission to Second Permittee, 17 POF3d 409.

"Permissive" Use of Automobile — use Within Scope of Permission Granted, 18 POF3d 433.

Identification of Hit-And-Run Vehicle and Driver, 60 POF3d 91.

33-34-1. Short title.

ADVISORY OPINIONS OF THE STATE BAR

Contingency fees. — Benefits paid under PIP coverage are assured; thus, the taking of a contingency fee for the filling out of routine, undisputed PIP claim forms is unreasonable and a violation of the Rules of the State Bar of Georgia. An attorney may charge a reasonable fee for

the attorney's time spent in processing a PIP claim. Adv. Op. No. 84-37 (January 20, 1984).

In those unusual circumstances when the payment of PIP benefits is not assured, the State Disciplinary Board does not prohibit contingency fees in general.

However, the attorney should examine the factors set out in DR 2-106(B) to determine whether a contingent fee arrangement would be reasonable. Adv. Op. No. 84-37 (January 20, 1984).

33-34-2. Definitions.

JUDICIAL DECISIONS

Cited in *Hewell v. Walton County*, 292 Ga. App. 510, 664 S.E.2d 875 (2008).

33-34-3. Requirements for issuance of policies.

Law reviews. — For annual survey of insurance law, see 56 Mercer L. Rev. 253 (2004).

JUDICIAL DECISIONS

No coverage meant no application of § 33-34-3. — Because the declarations page of an automobile insurance policy unequivocally showed that no liability coverage was purchased for the covered vehicle, O.C.G.A. § 33-34-3 did not apply. *Simlton v. AIU Ins. Co.*, 284 Ga. App. 152, 643 S.E.2d 553 (2007).

33-34-5.1. Self-insurers.

(a)(1) Except as otherwise provided in paragraphs (2) and (3) of this subsection, any person in whose name one or more vehicles are registered in this state may qualify as a self-insurer by obtaining a certificate of self-insurance from the Commissioner. The Commissioner may, in his or her discretion, upon the application of such person, issue such a certificate when he or she is satisfied that such person has and will continue to have the ability to provide coverages, benefits, and claims-handling procedures substantially equivalent to those afforded by a policy of vehicle insurance in compliance with this chapter.

(2) Except as otherwise provided in paragraph (3) of this subsection with regard to taxicabs, any person who operates one or more vehicles for hire which transport passengers and in whose name a certificate of title has been issued pursuant to Chapter 3 of Title 40 on one or more such vehicles may qualify as a self-insurer by obtaining a certificate of self-insurance from the Commissioner. The Commissioner may, in his or her discretion, upon the application of such person, issue such a certificate when he or she is satisfied that such person has and will continue to have the ability to provide coverages, benefits, and claims-handling procedures substantially equivalent to those afforded by a policy of vehicle insurance in compliance with this chapter.

(3)(A) As used in this paragraph, the term “taxicab” means a motor vehicle used to transport passengers for a fare and which is fitted with a taximeter to compute such fare.

(B) Any person who operates 25 or more taxicabs and in whose name such vehicles are registered may qualify as a self-insurer by obtaining a certificate of self-insurance from the Commissioner. The Commissioner may, in his or her discretion, upon the application of such person, issue such a certificate when he or she is satisfied that such person has and will continue to have the ability to provide coverages, benefits, and claims-handling procedures substantially equivalent to those afforded by a policy of vehicle insurance in compliance with this chapter. A person who operates fewer than 25 taxicabs and in whose name such vehicles are registered shall not be allowed to qualify as a self-insurer with regard to such vehicles.

(C) Except as otherwise provided in subparagraph (D) of this paragraph, on or after July 1, 1994, to qualify for a certificate of self-insurance under subparagraph (B) of this paragraph, a person shall maintain with the Commissioner a cash deposit of at least \$100,000.00 and shall also possess and thereafter maintain an additional amount of at least \$300,000.00 which shall be invested in the types of assets described in subparagraphs (A) through (H) of Code Section 33-11-5 and Code Sections 33-11-10, 33-11-14.1, 33-11-20, 33-11-21, and 33-11-25, which relate to various types of authorized investments for insurers.

(D) Any person operating as a self-insurer pursuant to a certificate of self-insurance issued prior to July 1, 1994, shall be allowed a transition period in which to meet the requirements of subparagraph (C) of this paragraph; provided, however, that, except as provided in subparagraph (G) of this paragraph, on and after December 31, 1995, all self-insurers under this paragraph shall comply fully with the requirements of subparagraph (C) of this paragraph. The Commissioner shall promulgate rules and regulations relative to the transition period for compliance provided in this subparagraph.

(E) Beginning July 1, 1994, and each year thereafter, a person operating as a self-insurer pursuant to this paragraph shall submit to the Commissioner, on forms prescribed by the Commissioner, reports of the business affairs and operations of the self-insurer in the same manner as required of insurers pursuant to Code Section 33-3-21. A person operating as a self-insurer pursuant to this paragraph shall also submit to the Commissioner an annual financial statement audited by an independent certified public accountant. The value of any asset listed in any report required by

this subparagraph shall be limited to the equity interest of the person operating as a self-insurer pursuant to this paragraph.

(F) Any person operating as a self-insurer pursuant to this paragraph shall be subject to examination and proceedings in the same manner applicable to insurers transacting motor vehicle insurance in this state as provided in Chapter 2 of this title and shall maintain reserves for losses in the same manner as insurers transacting motor vehicle insurance as provided in Chapter 10 of this title.

(G) Until December 31, 2003, the provisions of subparagraph (C) of this paragraph shall not apply to taxicab self-insurers which were located in counties with populations of 400,000 or less according to the United States decennial census of 1990 or any future such census and were licensed by the Commissioner on December 31, 1998.

(b)(1) In addition to the persons described in subsection (a) of this Code section, a religious organization that meets the requirements of this subsection may qualify as a self-insurer for motor vehicle liability insurance for all motor vehicles registered in this state that are owned or leased by members of such religious organization that obtains a certificate from the Commissioner. The Commissioner may, in his or her discretion, upon the application of such religious organization, issue a certificate when he or she is satisfied that such religious organization meets the qualifications of this subsection and has and will continue to have the ability to provide coverages, benefits, and claims-handling procedures substantially equivalent to those afforded by a policy of vehicle insurance in compliance with this chapter.

(2) In addition to any other rules or regulations established by the Commissioner, a religious organization seeking to obtain a certificate under the provisions of this subsection shall meet the following qualifications:

(A) The religious organization shall be a recognized sect or division of a recognized religious group having established tenets or teachings and shall have remained in existence continuously since December 31, 1950, and whose members hold a common belief in mutual financial assistance in time of need;

(B) The religious organization shall be a recognized sect or division of a religious group which has been a recognized religious group for purposes of exemption from federal social security and medicare taxes since December 31, 1970; and

(C) The religious organization has filed with the Commissioner the required minimum security. The required minimum security shall in no event be less than the following amounts:

Number of Vehicles	Required Security
1-50	\$150,000.00
51-100	\$200,000.00
101-150	\$300,000.00
151-200	\$350,000.00
201-250	\$400,000.00
251-350	\$500,000.00
351 or more	\$600,000.00

(3) The only forms of acceptable required minimum security shall be rendered in one or more of the following:

(A) United States currency placed as collateral with the Commissioner;

(B) Irrevocable letters of credit valid for a period of at least 24 months and renewable every 12 months and issued by a financial institution chartered by an agency of this state or the federal government; or

(C) Bonds or other negotiable obligations issued by this state, or a subdivision or instrumentality of this state, if not in default as to principal or interest.

(4) A certificate issued pursuant to this subsection shall be valid for a period of 12 months and may be renewed upon the religious organization's filing of an appropriate application, including a report of all claims incurred during the preceding calendar year, the number of covered motor vehicles, and proof that the organization continues to meet the requirements of this subsection. If, based upon the number of claims incurred by the organization during the preceding calendar year or the number of covered motor vehicles, the Commissioner determines that the required minimum security under this subsection is inadequate, the Commissioner may require additional minimum security or reports, or both.

(c) Upon a determination that any self-insurer, including a religious organization granted a certificate pursuant to subsection (b) of this Code section, has failed to pay on any valid claim within 30 days of its submission or has failed to satisfy any judgment within 30 days after such judgment shall become final, the Commissioner shall revoke such insurer's certificate. The Commissioner may on reasonable grounds cancel a certificate of self-insurance, including a certificate granted pursuant to subsection (b) of this Code section, and is authorized to promulgate rules and regulations prescribing such grounds for the cancellation of such certificates. (Ga. L. 1951, p. 565, § 16; Ga. L. 1956, p. 543, § 20; Ga. L. 1963, p. 593, § 10; Code 1933, § 68C-602, enacted by Ga. L. 1977, p. 1014, § 1; Code 1981, § 40-9-101; Ga. L. 1985, p. 989,

§ 1; Ga. L. 1988, p. 1488, § 1; Ga. L. 1994, p. 1931, § 2; Ga. L. 1995, p. 1060, § 1; Ga. L. 1995, p. 1348, § 9; Ga. L. 1996, p. 1079, § 2; Ga. L. 1997, p. 1042, § 2; Ga. L. 1998, p. 1205, § 1; Ga. L. 1999, p. 560, § 1A; Ga. L. 2000, p. 1246, § 15; Code 1981, § 33-34-5.1, as redesignated by Ga. L. 2000, p. 1246, § 16; Ga. L. 2010, p. 100, § 1/HB 656; Ga. L. 2011, p. 752, § 33/HB 142.)

The 2010 amendment, effective July 1, 2010, substituted “this chapter” for “Chapter 34 of Title 33” at the end of paragraphs (a)(1) and (a)(2), and at the end of the second sentence of subparagraph (a)(3)(B); added subsection (b); redesignated former subsection (b) as present subsection (c), and, in subsection (c), inserted “, including a religious organization granted a certificate pursuant to subsection (b) of this Code section,” near the beginning of the first sentence and inserted “, including a certificate granted pursuant to subsection (b) of this Code section,” in the second sentence.

The 2011 amendment, effective May 13, 2011, part of an Act to revise, modernize, and correct the Code, substituted “Commissioner” for “Commissioner of Insurance” throughout subsections (a) and (c); in paragraph (a)(2), substituted “Chapter 3 of Title 40” for “Chapter 3 of this title” in the first sentence; in subparagraph (a)(3)(F), substituted “Chapter 2 of this title” for “Chapter 2 of Title 33” and “Chapter 10 of this title” for “Chapter 10 of Title 33”; and in the introductory language of paragraph (b)(3), deleted “forms” from the end.

JUDICIAL DECISIONS

An exclusion in a car rental agreement, etc.

Exclusions from a policy of self-insurance contained in a car rental agreement were not required to be listed

in the car rental agency’s self-insurance plan filed with the insurance commissioner under O.C.G.A. § 33-34-5.1(a)(1). *Hix v. Hertz Corp.*, 307 Ga. App. 369, 705 S.E.2d 219 (2010).

33-34-6. Selection of motor vehicle repair facility.

Law reviews. — For annual survey of insurance law, see 56 Mercer L. Rev. 253 (2004).

JUDICIAL DECISIONS

No private cause of action. — Dismissal of an auto repair shop’s claim against an insurance company for violation of the Georgia Motor Vehicle Accident Reparations Act, O.C.G.A. § 33-34-1 et seq., was appropriate because there was

no private cause of action under O.C.G.A. § 33-34-6. *State Farm Mut. Auto. Ins. Co. v. Hernandez Auto Painting & Body Works*, 312 Ga. App. 756, 719 S.E.2d 597 (2011).

33-34-7. Continuation of coverage upon death of named insured or termination of marital relationship.

Law reviews. — For annual survey on insurance, see 61 Mercer L. Rev. 179 (2009).

33-34-9. Proceeds of insurance policy; limited access by insurers to records.

OPINIONS OF THE ATTORNEY GENERAL

Access to information in Registration and Title Information System. — The Department of Revenue is authorized to provide access to the information contained in the Georgia Registration and Title Information System only for the pur-

poses mandated by the Driver's Privacy Protection Act of 1994, 18 U.S.C. §§ 2721—2725, or to those state agencies designated in O.C.G.A. §§ 33-34-9, 40-2-130(c), and 40-3-23(d). 2008 Op. Att'y Gen. No. 2008-2.

CHAPTER 35

PREPAID LEGAL SERVICES PLANS

Sec.

33-35-15. Maintenance of books and records by sponsors; examination by Commissioner; reports of

examinations; payment of expenses of examinations.

33-35-15. Maintenance of books and records by sponsors; examination by Commissioner; reports of examinations; payment of expenses of examinations.

(a) The Commissioner shall require every sponsor of a prepaid legal services plan to retain at the address shown on its license the plan related books, records, accounts, and vouchers for a term of three years beginning immediately after the completion of the transaction and shall require that they be kept in such manner that the Commissioner or his authorized representatives may readily verify its annual statements and determine whether the plan and the sponsor are in compliance with the law.

(b) The Commissioner or his designee shall at least every three years visit each sponsor of a prepaid legal services plan and examine into such of its affairs as relate to the business of operating the plan. The Commissioner shall have free access to all plan related books, records, accounts, and vouchers of the plan and may summon and examine under oath officers, trustees, agents, and employees of the plan and any other persons regarding the affairs and condition of the plan; provided, however, that no written or oral information need be supplied under this or any other subsection of this chapter in violation of the attorney-client privilege as it is construed by the courts of this state.

(c) Every sponsor of a plan being examined and its officers, employees, and representatives shall produce and make freely accessible to the

Commissioner the accounts, records, documents, and files in its possession or control relating to the subject of the examination. The officers, employees, and representatives shall facilitate such examination and aid the examiners as far as it is in their power in making the examination.

(d)(1) The Commissioner shall make a full written report of each examination made by him containing only facts ascertained from the accounts, records, and documents examined and from the sworn testimony of witnesses.

(2) The report shall be certified by the Commissioner or by the examiner in charge of the examination and when so certified, after filing as provided in paragraph (3) of this subsection, shall be admissible in evidence in any proceeding brought by the Commissioner against the sponsor of the plan examined or any officer or agent of such sponsor and shall be prima-facie evidence of the facts stated in the report.

(3) The Commissioner shall furnish a copy of the proposed report to the sponsor of the plan examined not less than 20 days prior to filing the report. If the plan so requests in writing within the 20 day period or such longer period as the Commissioner may grant, the Commissioner shall grant a hearing with respect to the report and shall not file the report until after the hearing and such modifications have been made in the report as the Commissioner may deem proper.

(4) The Commissioner may withhold from public inspection the report of any examination or investigation for so long as he deems it to be in the public interest or necessary to protect the plan examined from unwarranted injury.

(5) After the report has been filed, the Commissioner may publish the report or the results of the report in one or more newspapers published in this state if he should deem it to be in the public interest.

(e) The sponsor of the plan so examined shall pay at the direction of the Commissioner all the actual travel and living expenses of the examination. When the examination is made by an examiner who is not a regular employee of the department, the sponsor examined shall pay the proper charges for the services of the examiner and his assistants in an amount approved by the Commissioner. A consolidated account for the examination shall be filed by the examiner with the Commissioner. No sponsor or other entity shall pay and no examiner shall accept any additional emolument on account of any examination. When the examination is conducted in whole or in part by regular salaried employees of the department, payment for the services and proper expenses shall be made by the sponsor examined to the Commissioner; and the payment shall be deposited with the Office of the State Treasurer. (Code

1933, § 56-3514, enacted by Ga. L. 1975, p. 1268, § 1; Ga. L. 1990, p. 8, § 33; Ga. L. 1993, p. 1402, § 18; Ga. L. 2010, p. 863, § 2/SB 296.)

The 2010 amendment, effective July 1, 2010, substituted “Office of the State Treasurer” for “Office of Treasury and Fiscal Services” at the end of subsection (e).

CHAPTER 36

GEORGIA INSURERS INSOLVENCY POOL

- Sec.
- 33-36-11. Limitation for filing claims; claims filed after final date set by court; default judgments.
- 33-36-14. Exhaustion of rights by claimants against insolvent insurers prior to recovery; recovery of payment to claimants in excess of amounts authorized; reduc-

- Sec.
- tion of liability of insured; recovery of amounts paid on behalf of certain persons.
- 33-36-20. Liability of pool to claimants and electing insureds in emergency circumstances; definitions; exceptions.

33-36-2. Creation; accounts; responsibility; supervision and regulation.

Editor’s notes. — Ga. L. 2006, p. 887, § 1, not codified by the General Assembly, amended Ga. L. 2005, p. 563, § 24, to read: “The provisions of Section 12 of this Act shall apply to insolvencies that occur

on or after the effective date of this Act. All other provisions shall apply as of the effective date of this Act.” Ga. L. 2005, p. 563, became effective July 1, 2005.

33-36-3. Definitions.

Editor’s notes. — Ga. L. 2006, p. 887, § 1, not codified by the General Assembly, amended Ga. L. 2005, p. 563, § 24, to read: “The provisions of Section 12 of this Act shall apply to insolvencies that occur

on or after the effective date of this Act. All other provisions shall apply as of the effective date of this Act.” Ga. L. 2005, p. 563, became effective July 1, 2005.

JUDICIAL DECISIONS

“Covered claims.” Georgia Insurers Insolvency Pool Act, O.C.G.A. § 33-36-1 et seq., did not bar assignee’s subrogation claim against an insolvent Florida corporation based on negligent construction of power lines that killed a worker in Georgia because it was not a “covered claim” under O.C.G.A.

§ 33-36-3(4); district court erred in barring the claim under the Florida Insurance Guaranty Association Act, Fla. Stat. § 631.54, because Florida law was not applicable under Georgia’s ex loci delicti choice of law rule. Federated Rural Elec. Ins. Exch. v. R. D. Moody & Assocs., 468 F.3d 1322 (11th Cir. 2006).

33-36-4. Insurers Solvency Board.

Editor's notes. — Ga. L. 2006, p. 887, § 1, not codified by the General Assembly, amended Ga. L. 2005, p. 563, § 24, to read: "The provisions of Section 12 of this Act shall apply to insolvencies that occur

on or after the effective date of this Act. All other provisions shall apply as of the effective date of this Act." Ga. L. 2005, p. 563, became effective July 1, 2005.

33-36-6. Plan to govern members; rules; requirements for plan; assignment of claims or judgments against insolvent insurers; claimants of assets of insolvent insurers; jurisdiction; venue.

Editor's notes. — Ga. L. 2006, p. 887, § 1, not codified by the General Assembly, amended Ga. L. 2005, p. 563, § 24, to read: "The provisions of Section 12 of this Act shall apply to insolvencies that occur

on or after the effective date of this Act. All other provisions shall apply as of the effective date of this Act." Ga. L. 2005, p. 563, became effective July 1, 2005.

33-36-7. Levy of assessments against insurers; reimbursement of expenses; refunds of assessments.

Editor's notes. — Ga. L. 2006, p. 887, § 1, not codified by the General Assembly, amended Ga. L. 2005, p. 563, § 24, to read: "The provisions of Section 12 of this Act shall apply to insolvencies that occur

on or after the effective date of this Act. All other provisions shall apply as of the effective date of this Act." Ga. L. 2005, p. 563, became effective July 1, 2005.

33-36-7.1. Surcharge on premiums to recoup assessments; disclosure to insureds; excess surcharges, exception where the expense of collection would exceed the amount of the surcharge.

Editor's notes. — Ga. L. 2006, p. 887, § 1, not codified by the General Assembly, amended Ga. L. 2005, p. 563, § 24, to read: "The provisions of Section 12 of this Act shall apply to insolvencies that occur

on or after the effective date of this Act. All other provisions shall apply as of the effective date of this Act." Ga. L. 2005, p. 563, became effective July 1, 2005.

33-36-9. Coverage afforded by insolvent insurers to become obligation of pool; investigation and settlement of claims by pool.

Editor's notes. — Ga. L. 2006, p. 887, § 1, not codified by the General Assembly, amended Ga. L. 2005, p. 563, § 24, to read: "The provisions of Section 12 of this Act shall apply to insolvencies that occur

on or after the effective date of this Act. All other provisions shall apply as of the effective date of this Act." Ga. L. 2005, p. 563, became effective July 1, 2005.

JUDICIAL DECISIONS

Cited in Royal Indem. Co. v. Ga. Insurers Insolvency Pool, 284 Ga. App. 787, 644 S.E.2d 279 (2007).

33-36-10. Recovery under chapter of covered claims recoverable under insolvency funds of other states.

JUDICIAL DECISIONS

Choice of law. — Georgia Insurers Insolvency Pool Act, O.C.G.A. § 33-36-1 et seq., did not bar assignee's subrogation claim against insolvent Florida insurer based on negligent construction of power lines that killed a worker in Georgia because it was not a "covered claim" under O.C.G.A. § 33-36-3(4); also, O.C.G.A. § 33-36-10 did not mandate application of the Florida Insurance Guaranty Associa-

tion Act, Fla. Stat. § 631.50-.70 because O.C.G.A. § 33-36-10 was intended to prevent duplicative recoveries when more than one state's insolvent insurer scheme applied, rather than to referee the more general question of which state's statutory scheme controlled in a conflict of law situation. *Federated Rural Elec. Ins. Exch. v. R. D. Moody & Assocs.*, 468 F.3d 1322 (11th Cir. 2006).

33-36-11. Limitation for filing claims; claims filed after final date set by court; default judgments.

(a) Notwithstanding any other provisions of this chapter, except as provided for in Code Section 33-36-20, a covered claim shall not include a claim filed with the pool after the earlier of (i) 18 months after the date of the order of liquidation, or (ii) the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer and shall not include any claim filed with the pool or a liquidator for protection afforded under the insured's policy for incurred but not reported losses.

(b) The pool may not be found in default. No default judgments may be entered against the pool, the insolvent insurer, or the insured of the insolvent insurer after the instigation of an insolvency proceeding prior to an order of liquidation, nor during the pendency of insolvency proceedings, nor during a 120 day stay following an order of liquidation.

(c) In no instance may a finding of default or the entry of a default judgment against an insurer be applicable or enforceable against the pool or the insured of the insolvent insurer. (Ga. L. 1970, p. 700, § 9; Ga. L. 1989, p. 74, § 7; Ga. L. 1992, p. 6, § 33; Ga. L. 2005, p. 563, § 18/HB 407; Ga. L. 2010, p. 1085, § 1/HB 1364.)

The 2010 amendment, effective June 4, 2010, in subsection (a), inserted "except as provided for in Code Section 33-36-20" near the beginning, and substituted "in-

curring but not reported" for "incurred-but-not-reported" near the end.

Editor's notes. — Ga. L. 2006, p. 887, § 1, not codified by the General Assembly,

amended Ga. L. 2005, p. 563, § 24, to read: "The provisions of Section 12 of this Act shall apply to insolvencies that occur on or after the effective date of this Act. All

other provisions shall apply as of the effective date of this Act." Ga. L. 2005, p. 563, became effective July 1, 2005.

33-36-13. Allowance of claims by receivers, liquidators, or statutory successors; appointment of pool as insurer's agent.

Editor's notes. — Ga. L. 2006, p. 887, § 1, not codified by the General Assembly, amended Ga. L. 2005, p. 563, § 24, to read: "The provisions of Section 12 of this Act shall apply to insolvencies that occur

on or after the effective date of this Act. All other provisions shall apply as of the effective date of this Act." Ga. L. 2005, p. 563, became effective July 1, 2005.

33-36-14. Exhaustion of rights by claimants against insolvent insurers prior to recovery; recovery of payment to claimants in excess of amounts authorized; reduction of liability of insured; recovery of amounts paid on behalf of certain persons.

(a) Except as provided for in Code Section 33-36-20, any person having a claim against a policy or an insured under a policy issued by an insolvent insurer, which claim is a covered claim and is also a claim within the coverage of any policy issued by a solvent insurer, shall be required to exhaust first his or her rights under such policy issued by the solvent insurer. The policy of the solvent insurer shall be treated as primary coverage and the policy of the insolvent insurer shall be treated as secondary coverage and his or her rights to recover such claim under this chapter shall be reduced by any amounts received from the solvent insurers.

(b) Any amount paid a claimant in excess of the amount authorized by this chapter may be recovered by an action brought by or on behalf of the pool.

(c) To the extent that the pool's obligation is reduced by the application of this Code section, the liability of the person insured by the insolvent insurer's policy for the claim shall be reduced in the same amount.

(d) Except as provided for in Code Section 33-36-20, the pool shall have the right to recover from the following persons all amounts paid by the pool on behalf of such person, whether for indemnity or defense or otherwise:

(1) Any insured whose net worth on December 31 of the year immediately preceding the date the insurer becomes an insolvent insurer exceeds \$25 million, provided that an insured's net worth on such date shall be deemed to include the aggregate net worth of the

insured and all of its subsidiaries and affiliates as calculated on a consolidated basis; and

(2) Any person who is an affiliate of the insolvent insurer. (Ga. L. 1970, p. 700, § 11; Ga. L. 1982, p. 3, § 33; Ga. L. 1989, p. 74, § 8; Ga. L. 2005, p. 563, § 20/HB 407; Ga. L. 2010, p. 1085, § 2/HB 1364; Ga. L. 2012, p. 1350, § 9/HB 1067.)

The 2010 amendment, effective June 4, 2010, in the first sentence of subsection (a), in the first sentence, substituted “Except as provided for in Code Section 33-36-20, any” for “Any” at the beginning, and inserted “or her” following “his” near the end; and, in the introductory language of subsection (d), substituted “Except as provided for in Code Section 33-36-20, the” for “The” at the beginning, substituted “any person who is an affiliate of the insolvent insurer” for “the following persons” near the middle, and deleted the colon at the end.

The 2012 amendment, effective July 1, 2012, in subsection (d), in the introductory paragraph, substituted “the following

persons” for “any person who is an affiliate of the insolvent insurer” near the middle and added a colon at the end, and substituted a comma for the semicolon following “25 million” in paragraph (d)(1).

Editor’s notes. — Ga. L. 2006, p. 887, § 1, not codified by the General Assembly, amended Ga. L. 2005, p. 563, § 24, to read: “The provisions of Section 12 of this Act shall apply to insolvencies that occur on or after the effective date of this Act. All other provisions shall apply as of the effective date of this Act.” Ga. L. 2005, p. 563, became effective July 1, 2005.

Law reviews. — For annual survey of law on workers’ compensation, see 62 Mercer L. Rev. 383 (2010).

JUDICIAL DECISIONS

No coverage by solvent insurer. — Passenger’s uninsured motorist (UM) insurer was not required to provide the \$15,000 bodily injury coverage afforded by the insolvent insurer for a permissive driver under O.C.G.A. § 33-36-14(a) because the UM insurer’s benefits were not available to the passenger as the owner’s UM coverage was not available to stack with the UM insurer’s coverage as the owner’s insurer was the liability insurer with respect to the single car accident; therefore, the passenger’s claim was not a claim within the coverage of a policy issued by the UM insurer as required by § 33-36-14. *Jefferson Ins. Co. v. Thomas*, 278 Ga. App. 89, 628 S.E.2d 171 (2006).

Court lacked subject matter jurisdiction under earlier provisions in subsection (a). — Because: (1) resolution of the issues raised in a petition filed by

the Georgia Insurers Insolvency Pool were dependent upon a determination by the State Board of Workers’ Compensation of the amount, if any, an injured employee was entitled to recover in the pending, unresolved claim for workers’ compensation; and (2) after a notice to controvert was filed, the Board never held a hearing or issued any findings with regard to liability for the claim, the trial court lacked subject matter jurisdiction to determine the applicability of earlier provisions of O.C.G.A. § 33-36-14(a) to the Pool’s claim against an insurer, after another carrier became insolvent, and hence, grant the Pool summary judgment in its declaratory judgment action. *Royal Indem. Co. v. Ga. Insurers Insolvency Pool*, 284 Ga. App. 787, 644 S.E.2d 279 (2007), cert. denied, 2007 Ga. LEXIS 639 (Ga. 2007).

33-36-14.1. Recommendations and report by the board of trustees.

Editor's notes. — Ga. L. 2006, p. 887, § 1, not codified by the General Assembly, amended Ga. L. 2005, p. 563, § 24, to read: "The provisions of Section 12 of this Act shall apply to insolvencies that occur

on or after the effective date of this Act. All other provisions shall apply as of the effective date of this Act." Ga. L. 2005, p. 563, became effective July 1, 2005.

33-36-15. Examination of pool.

Editor's notes. — Ga. L. 2006, p. 887, § 1, not codified by the General Assembly, amended Ga. L. 2005, p. 563, § 24, to read: "The provisions of Section 12 of this Act shall apply to insolvencies that occur

on or after the effective date of this Act. All other provisions shall apply as of the effective date of this Act." Ga. L. 2005, p. 563, became effective July 1, 2005.

33-36-16.1. Immunity from liability for performance of powers and duties under this chapter.

Editor's notes. — Ga. L. 2006, p. 887, § 1, not codified by the General Assembly, amended Ga. L. 2005, p. 563, § 24, to read: "The provisions of Section 12 of this Act shall apply to insolvencies that occur

on or after the effective date of this Act. All other provisions shall apply as of the effective date of this Act." Ga. L. 2005, p. 563, became effective July 1, 2005.

33-36-20. Liability of pool to claimants and electing insureds in emergency circumstances; definitions; exceptions.

(a) It is the policy of this state to protect insureds and their claimants from liability as a result of the insolvency of insurers. In furtherance of this policy, it is the intent of the legislature, notwithstanding any provision of law to the contrary, that the Georgia Insurers Insolvency Pool shall be liable to claimants and electing insureds in emergency circumstances.

(b) As used in this Code section, the term:

(1) "Electing insured" means any insured under a workers' compensation insurance policy that is impacted by an emergency circumstance. Such term shall include but not be limited to governmental insureds and other insureds under a workers' compensation insurance policy impacted by an emergency circumstance whose net worth exceeds \$25 million as of December 31 of the year preceding the filing of a claim.

(2) "Emergency circumstance" means a circumstance in which an association or industrial insured captive insurance company, including such a captive company that subsequently was authorized to transact business pursuant to Chapter 3 of this title, that is issuing,

or which has issued, workers' compensation insurance contracts and has been declared insolvent.

(3) "Emergency claimant" means any third-party claimant, under a workers' compensation insurance policy, who is impacted by an emergency circumstance and whose employer has, by a court of competent jurisdiction, been declared bankrupt or insolvent.

(c) Any electing insured whose net worth is less than \$25 million as of December 31 of the year preceding the filing of a claim may be shielded from liability by the pool and have any workers' compensation claims filed against such electing insured covered by the pool, provided said electing insured pays \$10,000.00 per claim to the insolvency pool prior to October 1, 2010. Any electing insured whose net worth exceeds \$25 million as of December 31 of the year preceding the filing of a claim may be shielded from liability by the pool and have any workers' compensation claims filed against such electing insured covered by the pool, provided said electing insured pays \$50,000.00 per claim to the insolvency pool prior to October 1, 2010. Claims of all emergency claimants shall be covered by the insolvency pool.

(d) Claimants shall retain the right to pursue claims against any insured that is not an electing insured. (Code 1981, § 33-36-20, enacted by Ga. L. 2010, p. 1085, § 3/HB 1364.)

Effective date. — This Code section became effective June 4, 2010.

CHAPTER 37

INSURERS REHABILITATION AND LIQUIDATION

ARTICLE 1

GENERAL PROVISIONS

33-37-1. Construction and purpose of chapter.

JUDICIAL DECISIONS

Trial court required to grant stay based on order of New York court. — Because a New York Order of Rehabilitation enjoined any actions, lawsuits, or proceedings against an insurance company, pursuant to O.C.G.A. § 33-37-23(a), the trial court was required to grant a stay

as to proceedings against the insurance company in order to give full faith and credit to the injunction ordered by the New York court. *Aon Risk Servs. v. Commercial & Military Sys. Co.*, 270 Ga. App. 510, 607 S.E.2d 157 (2004).

ARTICLE 3
PROCEDURE FOR REHABILITATION

33-37-23. Stay of collateral proceedings against insurer; authority of liquidator to intervene in, and defend, out-of-state action.

JUDICIAL DECISIONS

Trial court required to grant stay based on order of New York court. — Because a New York Order of Rehabilitation enjoined any actions, lawsuits, or proceedings against an insurance company, pursuant to O.C.G.A. § 33-37-23(a), the trial court was required to grant a stay

as to proceedings against the insurance company in order to give full faith and credit to the injunction ordered by the New York court. *Aon Risk Servs. v. Commercial & Military Sys. Co.*, 270 Ga. App. 510, 607 S.E.2d 157 (2004).

CHAPTER 38

GEORGIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

- Sec.
- 33-38-1. Purpose.
 - 33-38-2. Scope.
 - 33-38-3. Construction.
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- 33-38-15. Assessments against member insurers.
 - 33-38-16. Reports and recommendations as to solvency of companies; board may report information as to insolvency of member insurer; examinations of member insurers; reports of insurer insolvencies.
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33-38-1. Purpose.

The purpose of this chapter is to protect the persons specified in subsection (b) of Code Section 33-38-2, subject to certain limitations, against failure in the performance of contractual obligations, under life and health insurance policies and annuity contracts specified in subsection (a) of Code Section 33-38-2, due to the impairment or insolvency of the insurer issuing such policies or contracts. To provide this protection, (1) an association of insurers is created to enable the guaranty of payment of benefits and continuation of coverages as limited by this chapter, (2) members of the association are subject to assessment to provide funds to carry out the purpose of this chapter, and (3) the association is authorized to assist the Commissioner, in the prescribed manner, in the detection and prevention of insurer impairments or insolvencies. (Code 1933, § 56-2201, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 2012, p. 701, § 1/HB 786.)

The 2012 amendment, effective July 1, 2012, in the first sentence, substituted “the persons specified in subsection (b) of Code Section 33-38-2,” for “policy owners, insureds, beneficiaries, annuitants, payees, and assignees of life insurance policies, health insurance policies, annuity

contracts, and supplemental contracts,” and inserted “, under life and health insurance policies and annuity contracts specified in subsection (a) of Code Section 33-38-2;” and inserted “as limited by this chapter” in the second sentence.

33-38-2. Scope.

(a) This chapter shall provide coverage to the persons specified in subsection (b) of this Code section for direct, nongroup life, health, or annuity policies or contracts, for certificates under direct group policies and contracts, and for supplemental contracts to any of these, and for unallocated annuity contracts, in each case issued by member insurers, except as limited by this chapter. Annuity contracts and certificates under group annuity contracts include, but are not limited to, guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement annuities, annuities issued to or in connection with government lotteries, and any immediate or deferred annuity contracts.

(b)(1) Coverage under this chapter shall be provided only:

(A) To persons who, regardless of where they reside, except for nonresident certificate holders under group policies or contracts, are the beneficiaries, assignees, or payees of the persons covered under subparagraph (B) of this paragraph; and

(B) To persons who are owners of or certificate holders under such policies or contracts, other than unallocated annuity contracts and structured settlement annuities, to the persons who are the contract holders and who:

(i) Are residents; or

(ii) Are not residents, but the insurers which issued such policies or contracts are domiciled in this state; the states in which such persons reside have associations similar to the association created by this article; and such persons are not eligible for coverage by an association in any other state due to the fact that the insurer was not licensed in the state at the time specified in the state's guaranty association law.

(2) For unallocated annuity contracts specified in subsection (a) of this Code section, subparagraphs (A) and (B) of paragraph (1) of this subsection shall not apply, and this chapter shall, except as provided in paragraphs (4) and (5) of this subsection, provide coverage to:

(A) Persons who are the owners of the unallocated annuity contracts if the contracts are issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in this state; and

(B) Persons who are owners of unallocated annuity contracts issued to or in connection with government lotteries if the owners are residents.

(3) For structured settlement annuities specified in subsection (a) of this Code section, subparagraphs (A) and (B) of paragraph (1) of this subsection shall not apply, and this chapter shall, except as provided in paragraphs (4) and (5) of this subsection, provide coverage to a person who is a payee under a structured settlement annuity, or beneficiary of a payee if the payee is deceased, if the payee:

(A) Is a resident, regardless of where the contract owner resides; or

(B) Is not a resident, but only under both of the following conditions:

(i)(I) The contract owner of the structured settlement annuity is a resident; or

(II) The contract owner of the structured settlement annuity is not a resident, but the insurer that issued the structured settlement annuity is domiciled in this state and the state in which the contract owner resides has an association similar to the association created by this chapter; and

(ii) Neither the payee or beneficiary nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides.

(4) This chapter shall not provide coverage to:

(A) A person who is a payee or beneficiary of a contract owner who is a resident of this state, if the payee or beneficiary is afforded any coverage by the association of another state; or

(B) A person covered under paragraph (2) of this subsection, if any coverage is provided by the association of another state to that person.

(5) This chapter is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this chapter is provided coverage under the laws of any other state, the person shall not be provided coverage under this chapter. In determining the application of the provisions of this subsection in situations where a person could be covered by the association of more than one state, whether as an owner, payee, beneficiary, or assignee, this chapter shall be construed in conjunction with other state laws to result in coverage by only one association.

(c) This chapter shall not provide coverage to:

(1) That portion or part of a policy or contract not guaranteed by an insurer, or under which the risk is borne by the policy or contract owner;

(2) A policy or contract of reinsurance or any policy or contract or part thereof assumed by the impaired or insolvent insurer under a contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

(3) A portion of a policy or contract to the extent that the rate of interest on which it is based, or the interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:

(A) Averaged over the period of four years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting two percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four years before the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier; and

(B) On and after the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting

three percentage points from Moody's Corporate Bond Yield Average as most recently available;

(4) Any policy, contract, certificate, or subscriber agreement issued by a nonprofit hospital service corporation referred to in Chapter 19 of this title, a health care plan referred to in Chapter 20 of this title, a nonprofit medical service corporation referred to in Chapter 18 of this title, a prepaid legal services plan, as defined in Code Section 33-35-2, and a health maintenance organization, as defined in Code Section 33-21-1;

(5) Any policy, contract, or certificate issued by a fraternal benefit society, as defined in Code Section 33-15-1;

(6) Accident and sickness insurance as defined in Code Section 33-7-2 when written by a property and casualty insurer as part of an automobile insurance contract;

(7) A portion of a policy or contract issued to a plan or program of an employer, association, or other person to provide life, health, or annuity benefits to its employees, members, or others, to the extent that the plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association, or other person under:

(A) A multiple employer welfare arrangement as defined in 29 U.S.C. Section 1002(40);

(B) A minimum premium group insurance plan;

(C) A stop-loss insurance policy; or

(D) An administrative services only contract;

(8) A portion of a policy or contract to the extent that it provides for:

(A) Dividends or experience rating credits;

(B) Voting rights; or

(C) Payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;

(9) A policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this state;

(10) Any unallocated annuity contract issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation, regardless of whether the federal Pension Benefit Guar-

anty Corporation has yet become liable to make any payments with respect to the benefit plan;

(11) Any portion of any unallocated annuity contract which is not issued to or in connection with a specific employee, union, or association of natural persons benefit plan or a government lottery;

(12) A portion of a policy or contract to the extent that the assessments required by Code Section 33-38-15 with respect to the policy or contract are preempted by federal or state law;

(13) An obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contract owner or policy owner, including without limitation:

(A) Claims based on marketing materials;

(B) Claims based on side letters, riders, or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements;

(C) Misrepresentations of or regarding policy benefits;

(D) Extra-contractual claims; or

(E) A claim for penalties or consequential or incidental damages;

(14) A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer;

(15) A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this paragraph, the interest or change in value, determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture; or

(16) A policy or contract providing any hospital, medical, prescription drug, or other health care benefits pursuant to Part C or Part D.

of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code, commonly known as Medicare Part C & D, or any regulations issued pursuant thereto.

(d) The provisions of this Code section shall apply only to coverage the guaranty association provides in connection with any member insurer that is placed under an order of liquidation with a finding of insolvency after the effective date of this Code section. (Code 1933, § 56-2202, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 1984, p. 1080, § 5; Ga. L. 1988, p. 1900, § 1; Ga. L. 1995, p. 1348, § 5; Ga. L. 2012, p. 701, § 1/HB 786.)

The 2012 amendment, effective July 1, 2012, rewrote this Code section.

33-38-3. Construction.

This chapter shall be construed to effect the purpose set forth in Code Section 33-38-1. (Code 1933, § 56-2218, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 2012, p. 701, § 1/HB 786.)

The 2012 amendment, effective July 1, 2012, deleted “liberally” following “shall be” and deleted “, which Code section shall constitute an aid and guide to interpretation” following “33-38-1”.

33-38-4. Definitions.

As used in this chapter, the term:

(1) “Account” means any of the two accounts created under Code Section 33-38-5.

(2) “Affiliate” means any person that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with the person specified.

(3) “Association” means the Georgia Life and Health Insurance Guaranty Association created under Code Section 33-38-5.

(4) “Authorized assessment,” or “authorized” when used in the context of assessments, means a resolution by the board of directors of the association has been passed whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed.

(5) “Benefit plan” means a specific employee, union, or association of natural persons benefit plan.

(6) “Called assessment,” or “called” when used in the context of assessments, means that a notice has been issued by the association

to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.

(7) "Contractual obligation" means any obligation under a covered policy, contract, or certificate under a group policy or contract, or portion thereof for which coverage is provided under Code Section 33-38-2.

(8) "Control" or "controlled" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise.

(9) "Covered policy" means a policy or contract or portion of a policy or contract for which coverage is provided under Code Section 33-38-2.

(10) "Extra-contractual claims" shall include, for example, any claim not authorized by, or outside the scope of, the underlying policy or contract to include any claim based on bad faith, punitive or exemplary damages, treble damages, prejudgment or postjudgment interest, attorney's fees, or costs of litigation.

(11) "Impaired insurer" means a member insurer which is not an insolvent insurer and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction on or after July 1, 1981.

(12) "Insolvent insurer" means a member insurer against which an order of liquidation containing a finding of insolvency has been entered by a court of competent jurisdiction on or after July 1, 1981.

(13) "Member insurer" means any insurer which is licensed or which holds a certificate of authority to transact in this state any kind of insurance for which coverage is provided under Code Section 33-38-2 and includes any insurer whose license or certificate of authority in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn, but does not include:

(A) A hospital or medical service corporation, whether profit or nonprofit;

(B) A health care corporation;

(C) A health maintenance organization;

(D) A fraternal benefit society;

(E) A mandatory state pooling plan;

(F) A mutual assessment company or any entity that operates on an assessment basis;

(G) An insurance exchange;

(H) An organization that has a certificate or license limited to the issuance of charitable gift annuities under Code Sections 33-58-1 through 33-58-6; or

(I) Any entity similar to those described in subparagraphs (A) through (H) of this paragraph.

(14) “Moody’s Corporate Bond Yield Average” means the Monthly Average Corporates as published by Moody’s Investors Service, Inc., or any successor thereto.

(15) “Owner” of a policy or contract and “policy owner” and “contract owner” mean the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the insurer. The terms “owner,” “contract owner,” and “policy owner” shall not include persons with a mere beneficial interest in a policy or contract.

(16) “Person” means any individual, corporation, limited liability company, partnership, association, governmental body or entity, or voluntary organization.

(17) “Plan sponsor” means:

(A) The employer in the case of a benefit plan established or maintained by a single employer;

(B) The employee organization in the case of a benefit plan established or maintained by an employee organization; or

(C) In a case of a benefit plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan.

(18) “Premiums” means amounts or considerations, by whatever name called, received on covered policies or contracts, less returned premiums, considerations and deposits thereon and less dividends and experience credits. The term “premiums” shall not include:

(A) Amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided under this chapter except that assessable premium shall not be reduced on account of paragraph (3) of subsection (c) of Code

Section 33-38-2, relating to interest limitations, and paragraph (12) of Code Section 33-38-7, relating to limitations with respect to one individual, one participant, and one contract owner;

(B) Premiums in excess of \$5 million on an unallocated annuity contract; or

(C) With respect to multiple nongroup policies of life insurance owned by one owner, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, premiums in excess of \$5 million with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

(19)(A) "Principal place of business" of a plan sponsor or a person other than a natural person means the single state in which the natural persons who establish policy for the direction, control, and coordination of the operations of the entity as a whole primarily exercise that function, determined by the association in its reasonable judgment by considering the following factors:

(i) The state in which the primary executive and administrative headquarters of the entity is located;

(ii) The state in which the principal office of the chief executive officer of the entity is located;

(iii) The state in which the board of directors, or similar governing person or persons, of the entity conducts the majority of its meetings;

(iv) The state in which the executive or management committee of the board of directors, or similar governing person or persons, of the entity conducts the majority of its meetings;

(v) The state from which the management of the overall operations of the entity is directed; and

(vi) In the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the above factors.

However, in the case of a plan sponsor, if more than 50 percent of the participants in the benefit plan are employed in a single state, that state shall be deemed to be the principal place of business of the plan sponsor.

(B) The principal place of business of a plan sponsor of a benefit plan described in subparagraph (C) of paragraph (17) of this Code section shall be deemed to be the principal place of business of the

association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.

(20) "Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation, or liquidation of the insurer.

(21) "Resident" means any person who resides in this state at the time a member insurer is determined to be an impaired or insolvent insurer and to whom contractual obligations are owed. A person may be a resident of only one state, which, in the case of a person other than a natural person, shall be its principal place of business. Citizens of the United States who are either residents of foreign countries or residents of United States possessions, territories, or protectorates that do not have an association similar to the association created by this chapter shall be deemed residents of the state of domicile of the insurer that issued the policies or contracts.

(22) "State" means a state, the District of Columbia, Puerto Rico, and a United States possession, territory, or protectorate.

(23) "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

(24) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health, or annuity policy or contract.

(25) "Unallocated annuity contract" means an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate. (Code 1933, § 56-2203, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 1988, p. 1900, § 2; Ga. L. 1995, p. 1348, § 6; Ga. L. 2012, p. 701, § 1/HB 786.)

The 2012 amendment, effective July 1, 2012, rewrote this Code section.

33-38-5. Creation; required membership; functions and powers; supervision of association; accounts for administration and assessment.

(a) There is created a nonprofit, unincorporated association to be known as the Georgia Life and Health Insurance Guaranty Association.

All member insurers shall be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under the plan of operation established and approved under Code Section 33-38-8 and shall exercise its powers through a board of directors established under Code Section 33-38-6.

(b) The association shall come under the immediate supervision of the Commissioner and shall be subject to the applicable provisions of the insurance laws of this state.

(c) For purposes of administration and assessment, the association shall maintain two accounts: (1) the health insurance account; and (2) the life insurance and annuity account. The life insurance and annuity account shall contain three subaccounts: (A) the life insurance account; (B) the annuity account; and (C) the unallocated annuity account.

(d) For purposes of assessment, supplemental contracts shall be covered under the account in which the basic policy is covered. (Code 1933, § 56-2204, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1988, p. 1900, § 3; Ga. L. 2012, p. 701, § 1/HB 786.)

The 2012 amendment, effective July 1, 2012, deleted “which shall include contracts qualified under Section 403(b) of the United States Internal Revenue Code”

following “annuity account” near the end of subsection (c); and substituted “supplemental” for “supplementary” in subsection (d).

33-38-6. Membership of the board of directors; vacancies; compensation and reimbursement of expenses.

(a) The board of directors of the association shall consist of not less than five nor more than nine member insurers serving terms as established in the plan of operation. The members of the board shall be selected by the Commissioner from a list provided to the Commissioner from the board. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the Commissioner.

(b) In approving selections of members to the board, the Commissioner shall consider, among other things, whether all member insurers are fairly represented.

(c) Members of the board may be reimbursed from the assets of the association for reasonable expenses incurred by them in their capacity as members of the board of directors, but members of the board shall not otherwise be compensated by the association for their services. (Code 1933, § 56-2205, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 2012, p. 701, § 1/HB 786.)

The 2012 amendment, effective July 1, 2012, rewrote this Code section.

33-38-7. Powers and duties of the association generally.

(a) In addition to the powers and duties enumerated elsewhere in this chapter, the association shall have the following powers and duties:

(1) If a member insurer is an impaired insurer, the association, subject to any conditions, other than those conditions which impair the contractual obligations of the impaired insurer, imposed by the association and approved by the Commissioner, may, in its discretion:

(A) Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the covered policies or contracts of the impaired insurer; and

(B) Provide such moneys, pledges, loans, notes, guarantees, or other means as are proper to effectuate subparagraph (A) of this paragraph and assure payment of the contractual obligations of the impaired insurer pending action under subparagraph (A) of this paragraph;

(2) If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

(A)(i)(I) Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the covered policies or contracts of the insolvent insurer; or

(II) Assure payment of the contractual obligations of the insolvent insurer; and

(ii) Provide moneys, pledges, loans, notes, guarantees, or other means as are reasonably necessary to discharge the association's duties; or

(B) Provide benefits and coverages in accordance with the following provisions:

(i) With respect to life and health insurance policies and annuities, assure payment of benefits for premiums identical to the premiums and benefits, except for terms of conversion and renewability, that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred:

(I) With respect to group policies and contracts, not later than the earlier of the next renewal date under those policies or contracts or 45 days, but in no event less than 30 days, after the date on which the association becomes obligated with respect to the policies and contracts; and

(II) With respect to nongroup policies, contracts, and annuities, not later than the earlier of the next renewal date, if any, under the policies or contracts or one year, but in no event less than 30 days, from the date on which the association becomes obligated with respect to the policies or contracts;

(ii) Make diligent efforts to provide all known insureds or annuitants, for nongroup policies and contracts, or group policy owners with respect to group policies and contracts, 30 days' notice of the termination, pursuant to division (i) of this subparagraph, of the benefits provided;

(iii) With respect to nongroup life and health insurance policies and annuities covered by the association, make available to each known insured or annuitant, or owner if other than the insured or annuitant, and with respect to an individual formerly insured or formerly an annuitant under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of division (iv) of this subparagraph, if the insureds or annuitants had a right under law or the terminated policy or annuity to convert coverage to individual coverage or to continue an individual policy or annuity in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provision of the policy or annuity or had a right only to make changes in premium by class;

(iv) In providing the substitute coverage required under division (iii) of this subparagraph, the association may offer either to reissue the terminated coverage or to issue an alternative policy. Alternative or reissued policies shall be offered without requiring evidence of insurability and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy. The association may reinsure any alternative or reissued policy;

(v)(I) Alternative policies adopted by the association shall be subject to the approval of the domiciliary insurance commissioner. The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency.

(II) Alternative policies shall contain at least the minimum statutory provisions required in this state and provide benefits that shall not be unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates that it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and

class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy was last underwritten.

(III) Any alternative policy issued by the association shall provide coverage of a type similar to that of the policy issued by the impaired or insolvent insurer, as determined by the association;

(vi) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium shall be set by the association in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the domiciliary insurance commissioner and the receivership court;

(vii) The association's obligations with respect to coverage under any policy of the impaired or insolvent insurer or under any reissued or alternative policy shall cease on the date the coverage or policy is replaced by another similar policy by the policy owner, the insured, or the association; and

(viii) When proceeding under this subparagraph with respect to a policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with paragraph (3) of subsection (c) of Code Section 33-38-2;

(3) Nonpayment of premiums within 31 days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage shall terminate the association's obligations under the policy or coverage under this chapter with respect to the policy or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this chapter;

(4) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association. The association shall be liable for unearned premiums due to policy or contract owners arising after the entry of the order;

(5) The protection provided by this chapter shall not apply where any guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state;

(6) In carrying out its duties under paragraph (2) of this Code section, the association may:

(A) Subject to approval by a court in this state, impose permanent policy or contract liens in connection with a guarantee, assumption, or reinsurance agreement, if the association finds that the amounts which can be assessed under this chapter are less than the amounts needed to assure full and prompt performance of the association's duties under this chapter, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens, to be in the public interest; and

(B) Subject to approval by a court in this state, impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loans, or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court;

(7) A deposit in this state, held pursuant to law or required by the Commissioner for the benefit of creditors, including policy owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of an insurer domiciled in this state or in a reciprocal state, pursuant to Code Sections 33-3-8 through 33-3-10, shall be promptly paid to the association. The association shall be entitled to retain a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of policy owners claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy owners' claims in this state related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the association less the amount retained pursuant to this paragraph. Any amount so paid to the association and retained by it shall be treated as a distribution of estate assets pursuant to applicable state receivership law dealing with early access disbursements.

(8) If the association fails to act within a reasonable period of time with respect to an insolvent insurer, as provided in paragraph (2) of this Code section, the Commissioner shall have the powers and duties

of the association under this chapter with respect to the insolvent insurers;

(9) Upon the Commissioner's request, the association may render assistance and advice to the Commissioner concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer;

(10) The association shall have standing to appear or intervene before any court or agency in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this chapter or with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise. Such standing shall extend to all matters germane to the powers and duties of the association, including but not limited to proposals for reinsuring, modifying, or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association shall also have the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise;

(11)(A) Any person receiving benefits under this chapter shall be deemed to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from, or otherwise relating to, the covered policy or contract to the association to the extent of the benefits received because of this chapter, whether the benefits are payments of or on account of contractual obligations, continuation of coverage, or provision of substitute or alternative coverages. The association may require an assignment to it of such rights and causes of action by any payee, policy or contract owner, beneficiary, insured, or annuitant as a condition precedent to the receipt of any rights or benefits conferred by this chapter upon such person. The association shall be subrogated to these rights against the assets of any impaired or insolvent insurer.

(B) The subrogation rights of the association under this paragraph shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this chapter.

(C) In addition to subparagraphs (A) and (B) of this paragraph, the association shall have all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary,

or payee of a policy or contract with respect to the policy or contracts.

(D) If subparagraphs (A) through (C) of this paragraph are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies, or portion thereof, covered by the association.

(E) If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in this paragraph, the person shall pay to the association the portion of the recovery attributable to the policies, or portion thereof, covered by the association;

(12) The benefits that the association may become obligated to cover shall in no event exceed the lesser of:

(A) The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer;

(B) With respect to one life, regardless of the number of policies or contracts:

(i) The amount of \$300,000.00 in life insurance death benefits, but not more than \$100,000.00 in net cash surrender and net cash withdrawal values for life insurance;

(ii) In health insurance benefits, \$300,000.00 for disability insurance; \$300,000.00 for long-term care insurance; \$300,000.00 for health insurance other than disability insurance as referenced above, long-term care insurance as referenced above, and basic hospital, medical, and surgical insurance or major medical insurance as referenced below, including any net cash surrender and net cash withdrawal values; and \$500,000.00 for basic hospital, medical, and surgical insurance or major medical insurance; and

(iii) The amount of \$300,000.00 in the present value of annuity benefits, but not more than \$250,000.00 in net cash surrender and net cash withdrawal values for an annuity;

(C) With respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if deceased, \$300,000.00 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any;

(D) However, in no event shall the association be obligated to cover more than:

(i) An aggregate of \$300,000.00 in benefits with respect to any one life under subparagraph (B) of this paragraph except with respect to benefits for basic hospital, medical, and surgical insurance and major medical insurance under division (ii) of this subparagraph, in which case the aggregate liability of the association shall not exceed \$500,000.00 with respect to any one individual; or

(ii) With respect to one owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, more than \$5 million in benefits, regardless of the number of policies and contracts held by the owner;

(E) With respect to either one contract owner provided coverage under subparagraph (b)(2)(B) of Code Section 33-38-2 or one plan sponsor whose plans own directly or in trust one or more unallocated annuity contracts, \$5 million in benefits, regardless of the number of contracts with respect to the contract owner or plan sponsor. However, in the case where one or more unallocated annuity contracts are covered contracts under this chapter and are owned by a trust or other entity for the benefit of two or more plan sponsors, coverage shall be afforded by the association if the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in this state and in no event shall the association be obligated to cover more than \$5 million in benefits with respect to all these unallocated contracts; and

(F) The limitations set forth in this paragraph are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under this chapter may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights;

(13) In performing its obligations to provide coverage under Code Section 33-38-7, the association shall not be required to guarantee, assume, reinsure, or perform, or cause to be guaranteed, assumed, reinsured, or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not

materially affect the economic values or economic benefits of the covered policy or contract;

(14) In addition to the rights and powers elsewhere in this chapter, the association may:

(A) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this chapter;

(B) Sue or be sued, including the right to seek a declaratory judgment in any superior court of this state as to uncertainties with respect to the payment of benefits under this Code section. The association may also take any legal actions necessary or proper for recovery of any unpaid assessments under Code Section 33-38-15 and may settle claims or potential claims against it;

(C) Borrow money to effect the purposes of this chapter. Any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets;

(D) Employ or retain such persons as are necessary to handle the financial transactions of the association and to perform such other functions as become necessary or proper under this chapter;

(E) Negotiate and contract with any liquidator, rehabilitator, conservator, or ancillary receiver to carry out the powers and duties of the association;

(F) Take such legal action as may be necessary to avoid payment of improper claims; and

(G) Exercise, for the purposes of this chapter and to the extent approved by the Commissioner, the powers of a domestic life or health insurer; but in no case may the association issue insurance policies or annuity contracts other than those issued to perform its obligations under this chapter;

(15) Organize itself as a corporation or in other legal form permitted by the laws of the state;

(16) Request information from a person seeking coverage from the association in order to aid the association in determining its obligations under this chapter with respect to the person, and the person shall promptly comply with the request;

(17) Take other necessary or appropriate action to discharge its duties and obligations under this chapter or to exercise its powers under this chapter;

(18) The association may join an organization of one or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the association;

(19) With respect to covered policies for which the association becomes obligated after an entry of an order of liquidation, the association may elect to succeed to the rights of the insolvent insurer arising after the order of liquidation under any contract of reinsurance to which the insolvent insurer was a party, to the extent such contract provides coverage for losses occurring after the date of the order of liquidation. As a condition to making such election, the association must pay all unpaid premiums due under the contract for coverage relating to periods before and after the date on which the order of liquidation was entered;

(20) The board of directors shall have discretion and may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of this chapter in an economical and efficient manner;

(21) Where the association has arranged or offered to provide the benefits of this chapter to a covered person under a plan or arrangement that fulfills the association's obligations under this chapter, the person shall not be entitled to benefits from the association in addition to or other than those provided under the plan or arrangement;

(22) Exclusive venue in any action by or against the association is in the Superior Court of DeKalb County. The association may, at its option, waive such venue as to specific actions. The association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under this chapter; and

(23) In carrying out its duties in connection with guaranteeing, assuming, or reinsuring policies or contracts under paragraph (1) or (2) of this Code section, the association may, subject to approval of the receivership court, issue substitute coverage for a policy or contract that provides an interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

(A) In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for a fixed interest rate, payment of dividends with minimum guarantees, or a different method for calculating interest or changes in value;

(B) There is no requirement for evidence of insurability, waiting period, or other exclusion that would not have applied under the replaced policy or contract; and

(C) The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

(b) The provisions of this Code section shall apply only to coverage the guaranty association provides in connection with any member insurer that is placed under an order of liquidation with a finding of insolvency after the effective date of this Code section. (Code 1933, § 56-2206, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1988, p. 1900, § 4; Ga. L. 1993, p. 491, § 3; Ga. L. 2012, p. 701, § 1/HB 786.)

The 2012 amendment, effective July 1, 2012, rewrote this Code section.

33-38-8. Submission of plan of operation; contents; compliance with such plan.

Editor's notes. — Ga. L. 2012, p. 701, § 1/HB 786, effective July 1, 2012, reenacted this Code section without change. Refer to bound volume for text of this Code section.

33-38-9. Delegation of powers and duties of the association.

The plan of operation described in Code Section 33-38-8 may provide that any or all powers and duties of the association, except those under subparagraph (C) of paragraph (14) of Code Section 33-38-7 and Code Section 33-38-15, shall be delegated to a corporation, association, or other organization which performs or will perform functions similar to those of this association or its equivalent in two or more states. Such a corporation, association, or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation under this Code section shall take effect only with the approval of both the board of directors and the Commissioner and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided for by this chapter. (Code 1933, § 56-2208, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 1990, p. 8, § 33; Ga. L. 2012, p. 701, § 1/HB 786.)

The 2012 amendment, effective July 1, 2012, substituted “paragraph (14)” for “paragraph (10)” in the first sentence of this Code section.

33-38-10. Duties and powers of the Commissioner.

Editor's notes. — Ga. L. 2012, p. 701, § 1/HB 786, effective July 1, 2012, reenacted this Code section without change. Refer to bound volume for text of this Code section.

33-38-11. Records of meetings and negotiations of the association.

Records shall be kept of all negotiations and meetings in which the association or its representatives are involved to discuss the activities of the association in carrying out its powers and duties under Code Section 33-38-7. The records of the association with respect to an impaired or insolvent insurer shall not be disclosed prior to the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, except (a) upon the termination of the impairment or insolvency of the insurer, or (b) upon the order of a court of competent jurisdiction. Nothing in this Code section shall limit the duty of the association to render a report of its activities under Code Section 33-38-12. (Code 1933, § 56-2211, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 2012, p. 701, § 1/HB 786.)

The 2012 amendment, effective July 1, 2012, in the second sentence, substituted “The records of the association with respect to an impaired or insolvent insurer shall not be disclosed prior to” for

“Records of such negotiations or meetings shall be made public only upon” at the beginning, inserted “except (a)” near the middle, and inserted “(b)” near the end.

33-38-12. Examination of the association by the Commissioner; annual report.

The association shall be subject to examination and regulation by the Commissioner. Notwithstanding the foregoing, whether such examinations shall be conducted and the frequency of any such examination shall be at the sole discretion of the Commissioner. The board of directors shall submit to the Commissioner not later than May 1 of each year a financial report and a report of its activities for the preceding calendar year on forms approved by the Commissioner. (Code 1933, § 56-2212, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 2012, p. 701, § 1/HB 786.)

The 2012 amendment, effective July 1, 2012, added the second sentence.

33-38-13. Exemption of the association from taxation.

Editor’s notes. — Ga. L. 2012, p. 701, § 1/HB 786, effective July 1, 2012, reenacted this Code section without change.

Refer to bound volume for text of this Code section.

33-38-14. Immunity from liability for actions or omissions in performance of powers and duties pursuant to this chapter.

There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer or its agents or employees, the association or its agents or employees, members of the board of directors, or the Commissioner or his or her representatives, for any action or omission by them in the performance of their powers and duties under this chapter. This immunity shall extend to the participation in any organization of one or more other state associations of similar purposes and to any such organization and its agents or employees. (Code 1933, § 56-2214, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 2012, p. 701, § 1/HB 786.)

The 2012 amendment, effective July 1, 2012, in the first sentence of this Code section, inserted “or her” and substituted “action or omission” for “action taken”, and added the second sentence.

33-38-15. Assessments against member insurers.

(a) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers separately for the health account and for each subaccount of the life insurance and annuity account at such time and for such amounts as the board finds necessary. Assessment shall be due not less than 30 days after prior written notice to the member insurers.

(b) There shall be two classes of assessments, as follows:

(1) Class A assessments shall be authorized and called for the purpose of meeting administrative costs and legal and other general expenses not related to a particular impaired or insolvent insurer, and examinations conducted under the authority of subsection (c) of Code Section 33-38-16; and

(2) Class B assessments shall be authorized and called to the extent necessary to carry out the powers and duties of the association under Code Section 33-38-7 with regard to an impaired or insolvent insurer.

(c)(1) The amount of any Class A assessment shall be determined by the board of directors and may be made on a pro rata or non-pro rata basis. If a Class A assessment is made on a pro rata basis, the board may provide that it be credited against future Class B assessments. An assessment for costs and expenses other than for examinations which is made on a non-pro rata basis shall not exceed \$300.00 per company in any one calendar year. The amount of any Class B assessment shall be allocated for assessment purposes among the

accounts or subaccounts in subsection (c) of Code Section 33-38-5 pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances.

(2) Class B assessments against member insurers for each account or subaccount shall be in the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account or subaccount for the three most recent calendar years for which information is available preceding the year in which the insurer became impaired or insolvent, as the case may be, bears to such premiums received on business in this state for such calendar years by all assessed member insurers.

(3) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be authorized or called until necessary to implement the purposes of this chapter. Classification of assessments under subsection (b) of this Code section and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within 180 days after the assessment is authorized.

(d) The association may abate or defer in whole or in part the assessment of a member insurer if, in the opinion of the board of directors, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this Code section. Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

(e)(1) The total of all assessments upon a member insurer for each account shall not in any one calendar year exceed 2 percent of such insurer's premiums received in this state on the policies covered by the account during the calendar year preceding the assessment. If the maximum assessment in any account, together with the other assets of the association, does not provide in any one year in such account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by this chapter.

(2) The total of all assessments upon a member insurer for each subaccount of the life insurance and annuity account shall not in any

one calendar year exceed 2 percent of such insurer's premiums received in this state on the policies covered by the subaccount during the calendar year preceding the assessment. If the maximum assessment for any subaccount of the life insurance and annuity account in any one year does not provide an amount sufficient to carry out the responsibilities of the association, then the board shall assess the other subaccounts of the life insurance and annuity account for the necessary additional amount up to the maximum assessment level provided in paragraph (1) of this subsection.

(f) The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each insurer to that account or subaccount, the amount by which the assets of the account or subaccount exceed the amount the board finds is necessary to carry out the obligations of the association during the coming year with regard to that account or subaccount, including assets accruing from net realized gains and income from investments. A reasonable amount may be retained in any account or subaccount to provide funds for the continuing expenses of the association and for future losses if the board determines that refunds are impractical.

(g) It shall be proper for any member insurer in determining its premium rates and policy owner dividends as to any kind of insurance within the scope of this chapter to consider the amount reasonably necessary to meet its assessment obligations under this chapter.

(h) The association shall issue to each insurer paying an assessment under this chapter, other than a Class A assessment, a certificate of contribution, in a form prescribed by the Commissioner for the amount of the assessment paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in such form, for such an amount and for such period of time, not to exceed five years from the date of assessment, as the Commissioner may approve.

(i)(1) A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment shall be available to meet association obligations during the pendency of the protest or any subsequent appeal. Payment shall be accompanied by a statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest.

(2) Within 60 days following the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest.

(3) Within 30 days after a final decision has been made, the association shall notify the protesting member insurer in writing of that final decision. Within 60 days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the Commissioner.

(4) In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests to the Commissioner for a final decision, with or without a recommendation from the association.

(5) If the protest or appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member company. Interest on a refund due a protesting member shall be paid at the rate actually earned by the association.

(j) The association may request information of member insurers in order to aid in the exercise of its power under this Code section and member insurers shall promptly comply with a request. (Code 1933, § 56-2207, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1988, p. 1900, § 5; Ga. L. 1990, p. 1367, § 1; Ga. L. 2012, p. 701, § 1/HB 786.)

The 2012 amendment, effective July 1, 2012, substituted “shall be authorized and called” for “shall be made” in paragraphs (b)(1) and (b)(2); inserted “legal and” in paragraph (b)(1); substituted “\$300.00” for “\$150.00” in the third sen-

tence of paragraph (c)(1); in paragraph (c)(3), substituted “shall not be authorized or called” for “shall not be made” in the first sentence and added the third sentence; added the third sentence of subsection (d); and added subsections (i) and (j).

33-38-16. Reports and recommendations as to solvency of companies; board may report information as to insolvency of member insurer; examinations of member insurers; reports of insurer insolvencies.

(a) The board of directors may, upon majority vote, make reports and recommendations to the Commissioner upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer, or to the solvency of any company seeking to do an insurance business in this state. Such reports and recommendations shall not be considered public documents.

(b) The board of directors may, upon majority vote, notify the Commissioner of any information indicating any member insurer may be an impaired or insolvent insurer.

(c) The board of directors may, upon majority vote, request that the Commissioner order an examination of any member insurer which the board in good faith believes may be an impaired or insolvent insurer. Within 30 days of the receipt of such request, the Commissioner shall

begin such examination. The examination may be conducted as a National Association of Insurance Commissioners' examination or may be conducted by such persons as the Commissioner designates. The cost of such examination shall be paid by the association and the examination report shall be treated the same as other examination reports. In no event shall such examination report be released to the board of directors prior to its release to the public, but this shall not preclude the Commissioner from complying with subsection (a) of this Code section. The Commissioner shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the Commissioner, but it shall not be open to public inspection prior to the release of the examination report to the public.

(d) The board of directors may, upon majority vote, make recommendations to the Commissioner for the detection and prevention of insurer insolvencies.

(e) The board of directors shall, at the conclusion of any insurer insolvency in which the association was obligated to pay covered claims, prepare a report to the Commissioner containing such information as it may have in its possession bearing on the history and causes of such insolvency. The board shall cooperate with the board of directors of guaranty associations in other states in preparing a report on the history and causes of insolvency of a particular insurer and may adopt by reference any report prepared by such other associations. (Code 1933, § 56-2210, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 2012, p. 701, § 1/HB 786.)

The 2012 amendment, effective July 1, 2012, substituted the present provisions of subsection (b) for the former provisions, which read: "It shall be the duty of

the board of directors, upon majority vote, to notify the Commissioner of any information indicating any member insurer may be an impaired or insolvent insurer."

33-38-17. Assessment liability, association as creditor of insolvent or impaired insurer; distribution of insolvent insurer's ownership rights; reimbursement of association from disbursement of marshaled assets as available; recovery of distributions to affiliates.

(a) This chapter shall not be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

(b) For the purpose of carrying out its obligations under this chapter, the association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of the assets attributable to covered policies, reduced by any amounts to which the association is entitled as subrogee pursuant to paragraph (11) of Code Section 33-38-7. The assets of the impaired or insolvent insurer attributable to covered

policies shall be used by the association to continue the covered policies and pay the contractual obligations of the impaired or insolvent insurer as required by this chapter. For purposes of this subsection, that portion of the total assets of an impaired or insolvent insurer that is attributable to covered policies shall be determined by using the same proportion as the reserves that should have been established for such policies bears to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.

(c) As a creditor of the impaired or insolvent insurer as established in subsection (b) of this Code section and consistent with Code Section 33-37-33, the association and other similar associations shall be entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this chapter. If the liquidator has not, within 120 days of a final determination of insolvency of an insurer by the receivership court, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, then the association shall be entitled to make application to the receivership court for approval of its own proposal to disburse these assets.

(d)(1) Prior to the termination of any liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders, policy owners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of such insolvent insurer. In such a determination, consideration shall be given to the welfare of the policyholders of the continuing or successor insurer.

(2) No distribution to stockholders of an impaired or insolvent insurer shall be made until and unless the total amount of valid claims of the association with interest thereon for funds expended in carrying out its powers and duties under Code Section 33-38-7, with respect to such insurer, has been fully recovered by the association.

(3) No insurer that is subject to any delinquency proceedings, whether formal or informal, administrative or judicial, shall have any of its assets returned to the control of its shareholders or private management until all payments of or on account of the insurer's contractual obligations by all guaranty associations, along with all expenses thereof and interest on all such payments and expenses, shall have been repaid to the guaranty associations or a plan of repayment by the insurer shall have been approved by the guaranty association.

(e)(1) If an order for liquidation or rehabilitation of an insurer domiciled in this state has been entered, the receiver appointed under

such order shall have a right on behalf of the insurer to recover from any affiliate the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during the five years preceding the petition for liquidation or rehabilitation, subject to the limitations of this Code section.

(2) No such distribution shall be recoverable if the insurer shows that the distribution was lawful and reasonable when paid and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(3) Any person who was an affiliate that controlled the insurer at the time the distributions were paid shall be liable to the extent of the distributions received. Any person who was an affiliate that controlled the insurer at the time the distributions were declared shall be liable to the extent of the distributions that would have been received if such distributions had been paid immediately. Whenever two persons are liable with respect to the same distribution, they shall be jointly and severally liable.

(4) The maximum amount recoverable under this subsection shall be the amount needed, in excess of all other available assets of the insolvent insurer, to pay the contractual obligations of the insolvent insurer.

(5) Whenever any person liable under paragraph (3) of this subsection is insolvent, all affiliates that controlled it at the time the distribution was paid shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate. (Code 1933, § 56-2211, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 2012, p. 701, § 1/HB 786.)

The 2012 amendment, effective July 1, 2012, added subsection (a); redesignated former subsection (a) as present subsection (b); in subsection (b), substituted “paragraph (11)” for “paragraph (8)” in the first sentence and, in the second sentence, substituted “The assets” for “All assets” at the beginning and substituted “all” for “the” near the middle; added sub-

section (c); redesignated former subsection (b) as present subsection (d); in subsection (d), inserted “with interest thereon” near the middle of paragraph (d)(2) and added paragraph (d)(3); redesignated former subsection (c) as present subsection (e); and deleted “subsection and subsections (a) and (b) of this” preceding “Code section” in paragraph (e)(1).

33-38-18. Stay of court proceedings to which insolvent insurer is a party; setting aside of default judgments.

All proceedings in any court in this state in which the insolvent insurer is a party shall be stayed 180 days from the date of a final order of liquidation, rehabilitation, or conservation to permit proper legal action by the association on any matters germane to its powers or

duties. As to judgment entered under any decision, order, verdict, or finding based on default, the association may apply to have such judgment set aside by the same court that made such judgment and shall be permitted to defend against such action on the merits. (Code 1933, § 56-2215, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 2012, p. 701, § 1/HB 786.)

The 2012 amendment, effective July 1, 2012, substituted “180 days” for “60 days” in the first sentence of this Code section.

33-38-19. Notification as to effect of chapter.

Editor’s notes. — Ga. L. 2012, p. 701, § 1/HB 786, effective July 1, 2012, reenacted this Code section without change. Refer to bound volume for text of this Code section.

33-38-20. Appeal to the Commissioner; judicial review.

Any action of the board of directors may be appealed to the Commissioner by any member insurer if such appeal is taken within 60 days of its receipt of notice of the action being appealed. Any final action or order of the Commissioner shall be subject to judicial review in a court of competent jurisdiction in accordance with the laws of this state that may apply to the actions or orders of the Commissioner. (Code 1933, § 56-2209, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 2012, p. 701, § 1/HB 786.)

The 2012 amendment, effective July 1, 2012, substituted “60 days of its receipt of notice of” for “30 days of” in the first sentence and added “in accordance with the laws of this state that may apply to the actions or orders of the Commissioner” at the end of the second sentence.

33-38-21. References to the association in advertisements for insurance.

(a) No person, including an insurer or agent or affiliate of an insurer, shall make, publish, disseminate, circulate, or place before the public or cause directly or indirectly to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine, or other publication; in the form of a notice, circular, pamphlet, letter, or poster; over any radio station or television station; or in any other way, any advertisement, announcement, or statement which uses the existence of the association for the purposes of sales, solicitation, or inducement to purchase any form of insurance covered by this chapter. This Code section shall not apply to the association or any other entity which does not sell or solicit insurance.

(b) Any person who violates subsection (a) of this Code section may, after notice and hearing and upon order of the Commissioner, be subject to one or more of the following:

(1) A monetary penalty of not more than \$1,000.00 for each act or violation, but not to exceed an aggregate penalty of \$10,000.00; or

(2) Suspension or revocation of his or her license or certificate of authority. (Code 1933, § 56-2216, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 2012, p. 701, § 1/HB 786.)

The 2012 amendment, effective July 1, 2012, inserted “or her” in paragraph (b)(2).

33-38-22. Premium tax liability offsets; refunds offset against taxes.

Editor’s notes. — Ga. L. 2012, p. 701, § 1/HB 786, effective July 1, 2012, reenacted this Code section without change.

Refer to bound volume for text of this Code section.

CHAPTER 41

CAPTIVE INSURANCE COMPANIES

Sec.

33-41-20. Exclusion from insolvency funds; participation in FAIR plan or joint underwriting association; assessment for payments to Subsequent Injury Trust Fund.

Sec.

33-41-20.1. Membership of captive insurance companies in Georgia Insurers Insolvency Pool.

33-41-3. Permissible business; limitations.

JUDICIAL DECISIONS

Captive Insurance Company Act. — To the extent uninsured motorist provisions are inconsistent with the Georgia Captive Insurance Company Act, O.C.G.A. § 33-4-1 et seq., those provisions would not apply to captive insurance companies as set forth in the Act, O.C.G.A. § 33-41-24, because other controlling statutory mandates and strictures may result in the insurer providing some uninsured motorist coverage without being subject to other provisions of the unin-

sured motorist statute; the captive insurer is not required to insure a risk that the insurer is prohibited from insuring under the Act. *VFH Captive Ins. Co. v. Pleitez*, 307 Ga. App. 240, 704 S.E.2d 476 (2010).

Insurer entitled to uninsured motorist coverage. — Trial court did not err by finding that an insured was entitled to uninsured motorist coverage under the insured’s policy with a captive insurer because the policy the insurer issued to

the insured did not expressly include uninsured motorist coverage, and the insurer did not obtain a written rejection of that coverage from the insured; the accident involved the named insured, and the insured was engaged in responsibilities arising out of the insured's job as a taxi cab driver, not personal or family responsibilities, at the time the insured was injured. *VFH Captive Ins. Co. v. Pleitez*, 307 Ga. App. 240, 704 S.E.2d 476 (2010).

Captive Insurance Company Act does not prohibit uninsured motorist coverage. — There is nothing in the Georgia Captive Insurance Company Act, O.C.G.A. § 33-41-1 et seq., that explicitly prohibits a captive insurer from offering

uninsured motorist coverage, and thus the Act does not directly conflict with the requirement contained in O.C.G.A. § 33-7-11 that motor vehicle liability policies must include uninsured motorist coverage unless the insured has rejected that coverage in writing, but the mandate contained in the Act, O.C.G.A. § 33-41-3(b), is explicit; uninsured motorist coverage, unless rejected in writing, is such a minimum requirement under Georgia law, and the General Assembly is presumed to have acted with full knowledge of that requirement in enacting the provisions of the Act *VFH Captive Ins. Co. v. Pleitez*, 307 Ga. App. 240, 704 S.E.2d 476 (2010).

33-41-20. Exclusion from insolvency funds; participation in FAIR plan or joint underwriting association; assessment for payments to Subsequent Injury Trust Fund.

(a)(1) No captive insurance company other than an association or industrial insured captive insurance company issuing workers' compensation insurance contracts shall be permitted to join or contribute financially to the Georgia Insurers Insolvency Pool under Chapter 36 of this title or any other plan, pool, or association guaranty or insolvency fund in this state. Other than an association or industrial insured captive insurance company issuing workers' compensation insurance contracts, no captive insurance company, or its insureds or claimants against its insureds, nor its parent or any affiliated company shall receive any benefit from the Georgia Insurers Insolvency Pool or any other plan, pool, or association guaranty or insolvency fund for claims arising out of the operations of such captive insurance company.

(2) No captive insurance company shall be required to participate in any FAIR Plan established and maintained in this state under Chapter 33 of this title.

(3) No captive insurance company shall be required to participate in any joint underwriting association established and maintained in this state under Chapter 9 of this title.

(b) Captive insurance companies shall be assessed on the same basis as self-insurers for the purpose of payments to the Subsequent Injury Trust Fund as described in Chapter 9 of Title 34. (Code 1981, § 33-41-20, enacted by Ga. L. 1988, p. 966, § 2; Ga. L. 1989, p. 14, § 33; Ga. L. 2007, p. 236, § 1/HB 408.)

The 2007 amendment, effective January 1, 2008, in paragraph (a)(1), inserted “other than an association or industrial insured captive insurance company issuing workers’ compensation insurance contracts” in the first sentence, substituted “.

Other than an association or industrial insured captive insurance company issuing workers’ compensation insurance contracts, no” for “nor shall any” near the middle, and inserted “shall” near the middle of the last sentence.

33-41-20.1. Membership of captive insurance companies in Georgia Insurers Insolvency Pool.

(a) On and after January 1, 2008, every association and industrial insured captive insurance company issuing workers’ compensation insurance contracts shall become a member of the Georgia Insurers Insolvency Pool under Chapter 36 of this title as to workers’ compensation only. Such captive insurance companies shall be liable for assessments pursuant to Code Section 33-36-7 and for all other obligations imposed pursuant to Chapter 36 of this title as to workers’ compensation only.

(b) Except as provided for in Code Section 33-36-20, the Georgia Insurers Insolvency Pool shall not be liable for any claims incurred by any captive insurance company before January 1, 2008. (Code 1981, § 33-41-20.1, enacted by Ga. L. 2007, p. 236, § 2/HB 408; Ga. L. 2010, p. 1085, § 4/HB 1364.)

Effective date. — This Code section became effective January 1, 2008.

4, 2010, substituted “Except as provided for in Code Section 33-36-20, the” for “The” at the beginning of subsection (b).

The 2010 amendment, effective June

33-41-24. Inapplicability of inconsistent provisions.

JUDICIAL DECISIONS

Inconsistent uninsured motorist provisions not applicable to captive insurers. — To the extent uninsured motorist provisions are inconsistent with the Georgia Captive Insurance Company Act, O.C.G.A. § 33-4-1 et seq., those provisions would not apply to captive insurance companies as set forth in the Act, O.C.G.A. § 33-41-24, because other controlling statutory mandates and strictures may

result in the insurer providing some uninsured motorist coverage without being subject to other provisions of the uninsured motorist statute; the captive insurer is not required to insure a risk that the insurer is prohibited from insuring under the Act. *VFH Captive Ins. Co. v. Pleitez*, 307 Ga. App. 240, 704 S.E.2d 476 (2010).

CHAPTER 42

LONG-TERM CARE INSURANCE

Sec.
33-42-4. Definitions.

33-42-1. Short title.

Cross references. — Georgia
Long-term Care Partnership Program
Act, § 49-4-160 et seq.

33-42-4. Definitions.

As used in this chapter, the term:

(1) “Applicant” means:

(A) In the case of an individual long-term care insurance policy, the person who seeks to contract for such benefits; and

(B) In the case of a group long-term care insurance policy, the proposed certificate holder.

(2) “Certificate” means any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state.

(3) “Commissioner” means the Commissioner of Insurance of this state.

(4) “Group long-term care insurance” means a long-term care insurance policy which is issued, delivered, or issued for delivery in this state and issued to:

(A) Any eligible group as defined in Code Section 33-30-1; or

(B) A group other than as described in Code Section 33-30-1, subject to a finding by the Commissioner that:

(i) The issuance of the group policy is not contrary to the best interest of the public;

(ii) The issuance of the group policy would result in economies of acquisition or administration; and

(iii) The benefits are reasonable in relation to the premiums charged.

(5) “Long-term care insurance” means any accident and sickness insurance policy or rider advertised, marketed, offered, or designed primarily to provide coverage for not less than 12 consecutive benefit

months or which provides coverage for recurring confinements separated by a period not to exceed six months with a minimum aggregate period of one year for each covered person on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes group and individual accident and sickness policies or riders whether issued by insurers, fraternal benefit societies, nonprofit hospital service corporations, nonprofit medical service corporations, health care plans, health maintenance organizations, or any other similar organizations. Long-term care insurance shall not include any accident and sickness insurance policy which is offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, catastrophic coverage, comprehensive coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. Long-term care insurance may be provided through an individual or group life insurance policy by attachment of a long-term care rider or by the automatic inclusion of a long-term care provision which, notwithstanding Code Section 33-42-3, must meet the requirements of this chapter and regulations promulgated by the Commissioner. Any such long-term care riders or policy provisions shall not be exempt from filing requirements and must be filed with the department for approval before being used in this state.

(6) "Policy" means any policy, contract, or subscriber agreement or any rider or endorsement attached thereto, issued, delivered, issued for delivery, or renewed in this state by an insurer, fraternal benefit society, nonprofit hospital service corporation, nonprofit medical service corporation, health care plan, health maintenance organization, or any other similar organization. Such term shall also include a Georgia Qualified Long-term Care Partnership Program approved policy, as defined in paragraph (4) of Code Section 49-4-161, meeting the requirements of the Georgia Qualified Long-term Care Partnership Program as enacted in subsection (a) of Code Section 49-4-162. (Code 1981, § 33-42-4, enacted by Ga. L. 1988, p. 1541, § 1; Ga. L. 1989, p. 894, § 1; Ga. L. 2007, p. 239, § 1/HB 648.)

The 2007 amendment, effective July 1, 2007, in the first sentence of paragraph (5), substituted "12" for "24" and substi-

tuted "one year" for "two years"; and added the last sentence in paragraph (6).

CHAPTER 43

MEDICARE SUPPLEMENT INSURANCE

Sec.

33-43-3. Duplicate benefits prohibited;
establishment of standards.

33-43-3. Duplicate benefits prohibited; establishment of standards.

(a) No medicare supplement insurance policy or certificate in force in this state shall contain benefits which duplicate benefits provided by medicare.

(b) Notwithstanding any other provision of Georgia law, a medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

(c) The Commissioner shall adopt reasonable regulations to establish specific standards for policy provisions of medicare supplement policies and certificates. Such standards shall be in addition to and in accordance with applicable laws of this state. No requirement of this title relating to minimum required policy benefits, other than the minimum standards contained in this chapter, shall apply to medicare supplement policies and certificates. The standards shall cover, but shall not be limited to:

- (1) Terms of renewability;
- (2) Initial and subsequent conditions of eligibility;
- (3) Nonduplication of coverage;
- (4) Probationary periods;
- (5) Benefit limitations, exceptions, and reductions;
- (6) Elimination periods;
- (7) Requirements for replacement;
- (8) Recurrent conditions; and
- (9) Definitions of terms.

(d) The Commissioner shall adopt reasonable regulations to establish minimum standards for benefits, claims payment, marketing

practices, compensation arrangements, and reporting practices for medicare supplement policies and certificates.

(e) The Commissioner may adopt from time to time such reasonable regulations as are necessary to conform medicare supplement policies and certificates to the requirements of federal law and regulations promulgated thereunder, including, but not limited to:

- (1) Requiring refunds or credits if the policies or certificates do not meet loss ratio requirements;
- (2) Establishing a uniform methodology for calculating and reporting loss ratios;
- (3) Assuring public access to policies, premiums, and loss ratio information of issuers of medicare supplement insurance;
- (4) Establishing a process for approving or disapproving policy forms, certificate forms, and proposed premium increases;
- (5) Establishing a policy for holding public hearings prior to approval of premium increases; and
- (6) Establishing standards for medicare select policies and certificates.

(f) The Commissioner may adopt reasonable regulations that specify prohibited policy provisions not otherwise specifically authorized by statute which, in the opinion of the Commissioner, are unjust, unfair, or unfairly discriminatory to any person insured or proposed to be insured under a medicare supplement policy or certificate.

(g) Insurers offering medicare supplement policies in this state to persons 65 years of age or older shall also offer medicare supplement policies to persons in this state who are eligible for and enrolled in medicare by reason of disability or end-stage renal disease. Except as otherwise provided in this Code section, all benefits, protections, policies, and procedures that apply to persons 65 years of age or older shall also apply to persons who are eligible for and enrolled in medicare by reason of disability or end-stage renal disease.

(h) Persons may enroll in a medicare supplement policy at any time authorized or required by the federal government or within six months of:

- (1) Enrolling in medicare Part B or by May 1, 2011, for an individual who is under 65 years of age and is eligible for medicare because of disability or end-stage renal disease, whichever is later;

(2) Receiving notice that such person has been retroactively enrolled in medicare Part B due to a retroactive eligibility decision made by the Social Security Administration; or

(3) Experiencing a qualifying event identified in regulations adopted pursuant to subsection (c) of this Code section.

(i) No policy or certificate issued pursuant to this chapter shall prohibit payment made by third parties on behalf of individual applicants or individuals within a group applicant so long as:

(1) The third party is an immediate family member of a person lawfully exercising an in-force power of attorney or legal guardianship; or

(2) The third party is a nonprofit, charitable organization that:

(A) Is the named requestor of an advisory opinion issued by the United States Department of Health and Human Services (HHS) Office of Inspector General under the requirements of 42 C.F.R. Part 1008; and

(B) Provides, upon request by the medicare supplement issuer, the specific advisory opinion relied upon by the third party to make such payment and a written certification that the advisory opinion is in full force and effect and has not been rescinded, modified, or terminated by the United States Department of Health and Human Services (HHS) Office of Inspector General.

(j) Premiums for medicare supplemental insurance policies may differ between persons who qualify for medicare who are 65 years of age or older and those who qualify for medicare who are younger than 65 years of age; provided, however, that such differences in premiums shall not be excessive, inadequate, or unfairly discriminatory and shall be based on sound actuarial principles and reasonable in relation to the benefits provided. (Code 1981, § 33-43-3, enacted by Ga. L. 1992, p. 1395, § 1; Ga. L. 1993, p. 91, § 33; Ga. L. 1996, p. 705, § 19; Ga. L. 2010, p. 120, § 1/SB 316; Ga. L. 2011, p. 752, § 33/HB 142.)

The 2010 amendment, effective November 1, 2010, substituted “shall” for “may” near the end of the introductory paragraph of subsection (c); and added subsections (g) through (j).

The 2011 amendment, effective May

13, 2011, part of an Act to revise, modernize, and correct the Code, in subsection (g), substituted “persons who are eligible” for “persons that are eligible” in the last sentence; and revised punctuation in subsection (h) and paragraph (h)(1).

CHAPTER 44

HIGH RISK HEALTH INSURANCE PLAN

Sec.

33-44-3. (For effective date, see note.)
Georgia High Risk Health Insurance Plan created; board of

directors; method of operation for plan; powers of plan.

Delayed effective date. — Ga. L. 1989, p. 1701, § 2, provided that the enactment of this chapter by the Act shall become effective on July 1, 1989, only for the purposes of the appointment of the board of directors and the establishment of elements of the method of operation of the plan by the board. The Act shall become effective for all purposes only upon

the appropriation of funds by the General Assembly necessary to carry out the purposes of the Act. No such funds were appropriated during the 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, or 2012 sessions of the General Assembly.

33-44-3. (For effective date, see note.) Georgia High Risk Health Insurance Plan created; board of directors; method of operation for plan; powers of plan.

(a) There is created a body corporate and politic to be known as the “Georgia High Risk Health Insurance Plan” which shall be deemed to be an instrumentality of the state and a public corporation. The Georgia High Risk Health Insurance Plan shall have perpetual existence and any change in the name or composition of the plan shall in no way impair the obligations of any contracts existing under this chapter. The Georgia High Risk Health Insurance Plan is assigned to the Department of Insurance for administrative purposes only as prescribed in Code Section 50-4-3.

(b) There is created a board of directors of the Georgia High Risk Health Insurance Plan to be composed of ten members appointed as provided in this subsection and the Commissioner of Insurance, who shall serve as an ex officio member. The Commissioner shall appoint, with the approval of the Governor, one member who shall represent domestic insurers licensed to transact accident and sickness insurance in this state, one member who shall represent a domestic nonprofit health care service plan, and one member who shall be a hospital administrator. The Governor shall appoint two members who shall be consumers, one member who shall represent employers who have more than 25 employees, one member who shall represent employers who have less than 25 employees, one member who shall represent health maintenance organizations, one member who shall be a licensed physician, and one member who shall either be a representative of the

Department of Public Health or a representative of a government agency involved directly or indirectly in state-wide health planning. All members of the board shall serve for terms of six years, except the Commissioner whose term shall be concurrent with his term of office as Commissioner. The board shall select one of its members to serve as chairman. The members of the board of directors shall be required to take and subscribe before the Governor an oath to discharge the duties of their office faithfully and impartially. This oath shall be in addition to the oath required of all civil officers. The members of the board of directors shall not be entitled to compensation for their services but shall be entitled to reimbursement for their actual travel and expenses necessarily incurred in the performance of their duties when funds are available for this purpose.

(c) The board of directors shall establish a method of operation for the plan and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the plan. The method of operation and any amendments thereto shall be submitted to the Commissioner for his evaluation and he shall make recommendations to the board of directors if he feels revisions are required to assure the fair, reasonable, and equitable administration of the plan. The Commissioner shall, after notice and hearing, approve the method of operation, provided such is determined to be suitable to assure the fair, reasonable, and equitable administration of the plan. The method of operation shall become effective upon approval in writing by the Commissioner consistent with the date on which the coverage under this chapter may be made available. If the plan fails to submit a suitable method of operation within 180 days after the appointment of the board of directors or at any time thereafter fails to submit suitable amendments to the plan, the Commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this Code section. Such rules shall continue in force until modified by the Commissioner or superseded by a method of operation submitted by the board and approved by the Commissioner.

(d) In the method of operation the directors shall:

(1) Establish procedures for the handling and accounting of assets and moneys of the plan;

(2) Select an administrator, which shall be an insurer licensed to transact accident and sickness insurance in this state, in accordance with Code Section 33-44-5;

(3) Establish procedures for filling vacancies on the board of directors;

(4) Establish a fixed benefit schedule for the payment of benefits and cost containment features designed to assist in controlling the costs of the plan; and

(5) Develop and implement a program to publicize the existence of the plan, the eligibility requirements, and the procedures for enrollment and to maintain public awareness of the plan.

(e) The plan shall have the general powers and authority granted under the laws of this state to insurance companies licensed to transact accident and sickness insurance as defined under Code Section 33-44-2 and, in addition thereto, the specific authority to:

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this chapter, including the authority to enter into contracts with similar funds or pools of other states for the joint performance of common administrative functions or with persons or other organizations for the performance of administrative functions. The plan shall have the authority to establish reciprocal agreements with similar pools or funds of other states and may agree to waive the residency requirement specified in subsection (a) of Code Section 33-44-4 with respect to persons who become residents of this state and were covered under a similar pool or fund with which the plan had established a reciprocal agreement;

(2) Bring or defend actions;

(3) Take such legal action as necessary to avoid the payment of improper claims against the plan or the coverage provided by or through the plan;

(4) Establish appropriate rates; rate schedules; rate adjustments; expense allowances; agents' referral fees; claim reserve formulas; cost containment features, including, but not limited to, second opinions for surgeries, review and auditing of claims, precertification of hospital admissions and surgeries, and preferred providers; and any other actuarial functions appropriate to the operation of the plan. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim cost and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices;

(5) Issue policies or certificates of insurance coverage in accordance with the requirements of this chapter; and

(6) Establish rules, conditions, and procedures for reinsurance of risks of the plan. (Code 1981, § 33-44-3, enacted by Ga. L. 1989, p. 1701, § 1; Ga. L. 1990, p. 8, § 33; Ga. L. 2009, p. 453, § 1-4/HB 228; Ga. L. 2011, p. 705, § 6-3/HB 214.)

The 2009 amendment, effective July 1, 2009, substituted “Department of Community Health” for “Department of Human Resources” in the third sentence of subsection (b).

The 2011 amendment, effective July 1, 2011, substituted “Department of Public Health” for “Department of Community Health” in the third sentence of subsection (b).

Editor’s notes. — For information as to the effective date of this Code section, see the delayed effective date note at the beginning of this chapter.

Law reviews. — For article on the 2011 amendment of this Code section, see 28 Ga. St. U. L. Rev. 147 (2011).

CHAPTER 45

CONTINUING CARE PROVIDERS AND FACILITIES

Sec.	Sec.
33-45-1. Definitions.	33-45-8. Portion of entrance fee paid by resident to be held in escrow account.
33-45-2. Use of powers; providers or facilities charging an entrance fee.	33-45-9. Provisions of this chapter not subject to waiver.
33-45-3. Certificate of authority required for operation of continuing care facilities.	33-45-10. Information disclosure requirements.
33-45-4. Administration by Insurance Department.	33-45-11. Maintaining financial reserves; requirements.
33-45-5. Application for approval or renewal of certificate of authority.	33-45-12. Actions for recovery of damages and attorney’s fees.
33-45-6. Annual revised disclosure statement; statement to be made available to all residents of facility; submission of other necessary information as determined by Commissioner.	33-45-13. Penalties for violation of chapter provisions; department authorized to take remedial action, including suspension and revocation of certificate of authority.
33-45-7. Requirements for continuing care agreements, addenda, and amendments.	33-45-14. Period of applicability of chapter.

33-45-1. Definitions.

As used in this chapter, the term:

(1) “Continuing care” or “care” means furnishing pursuant to an agreement lodging that is not in a skilled nursing facility as defined in paragraph (34) of Code Section 31-6-2, an intermediate care facility as defined in paragraph (22) of Code Section 31-6-2, or a personal care home as defined in Code Section 31-7-12; food; and nursing care, whether such nursing care is provided in the facility or in another setting designated by the agreement for continuing care, to an

individual not related by consanguinity or affinity to the provider furnishing such care upon payment of an entrance fee.

(2) "Continuing care agreement" means a contract or agreement to provide continuing care or limited continuing care. Agreements to provide continuing care or limited continuing care include agreements to provide care for any duration, including agreements that are terminable by either party.

(3) "Entrance fee" means an initial or deferred payment of a sum of money or property made as full or partial payment to assure the resident continuing care or limited continuing care; provided, however, that any such initial or deferred payment which is greater than or equal to 12 times the monthly care fee shall be presumed to be an entrance fee so long as such payment is intended to be a full or partial payment to assure the resident lodging in a residential unit. An accommodation fee, admission fee, or other fee of similar form and application greater than or equal to 12 times the monthly care fee shall be considered to be an entrance fee.

(4) "Facility" means a place in which it is undertaken to provide continuing care or limited continuing care.

(5) "Licensed" means that the provider has obtained a certificate of authority from the department.

(6) "Limited continuing care" means furnishing pursuant to an agreement lodging that is not in a skilled nursing facility as defined in paragraph (34) of Code Section 31-6-2, an intermediate care facility as defined in paragraph (22) of Code Section 31-6-2, or a personal care home as defined in Code Section 31-7-12; food; and personal services, whether such personal services are provided in a facility such as a personal care home or in another setting designated by the continuing care agreement, to an individual not related by consanguinity or affinity to the provider furnishing such care upon payment of an entrance fee.

(7) "Monthly care fee" means the fee charged to a resident for continuing care or limited continuing care on a monthly or periodic basis. Monthly care fees may be increased by the provider to provide care to the resident as outlined in the continuing care agreement. Periodic fee payments or other prepayments shall not be monthly care fees.

(8) "Nursing care" means services which are provided to residents of skilled nursing facilities or intermediate care facilities.

(9) "Personal services" means, but is not limited to, such services as individual assistance with eating, bathing, grooming, dressing, ambulation, and housekeeping; supervision of self-administered

medication; arrangement for or provision of social and leisure services; arrangement for appropriate medical, dental, nursing, or mental health services; and other similar services which the department may define. Personal services shall not be construed to mean the provision of medical, nursing, dental, or mental health services by the staff of a facility. Personal services provided, if any, shall be designated in the continuing care agreement.

(10) "Provider" means the owner or operator, whether a natural person, partnership, or other unincorporated association, however organized, trust, or corporation of an institution, building, residence, or other place, whether operated for profit or not, which owner or operator undertakes to provide continuing care or limited continuing care for a fixed or variable fee, or for any other remuneration of any type, whether fixed or variable, for the period of care, payable in a lump sum or lump sum and monthly maintenance charges or in installments.

(11) "Resident" means a purchaser of or a nominee of or a subscriber to a continuing care agreement. Such an agreement shall not be construed to give the resident a part ownership of the facility in which the resident is to reside unless expressly provided for in the agreement.

(12) "Residential unit" means a residence or apartment in which a resident lives that is not a skilled nursing facility as defined in paragraph (34) of Code Section 31-6-2, an intermediate care facility as defined in paragraph (22) of Code Section 31-6-2, or a personal care home as defined in Code Section 31-7-12. (Code 1981, § 33-45-1, enacted by Ga. L. 1990, p. 1817, § 1; Ga. L. 2011, p. 315, § 1/SB 166.)

The 2011 amendment, effective July 1, 2011, rewrote this Code section.

33-45-2. Use of powers; providers or facilities charging an entrance fee.

(a) For the purpose of enforcing the requirements of this chapter, the Commissioner and the department shall be authorized to use the powers granted in Chapters 1 and 2 of this title.

(b) A provider or facility which charges a resident an entrance fee for lodging in a residential unit and provides limited continuing care shall not call itself nor be considered a provider of continuing care, but such provider or facility shall otherwise be subject to the requirements imposed upon the providers and facilities regulated by this chapter; provided, however, that a facility that has received a certificate of authority and has been in conformance with the provisions of this chapter prior to July 1, 2011, may continue to call and present itself to

the public as a provider of continuing care. (Code 1981, § 33-45-2, enacted by Ga. L. 1990, p. 1817, § 1; Ga. L. 2011, p. 315, § 1/SB 166.)

The 2011 amendment, effective July 1, 2011, substituted the present provisions of this Code section for the former provisions, which read: "Except as provided in this chapter, providers of continu-

ing care facilities shall be governed by the provisions of this chapter and shall be exempt from all other provisions of this title."

33-45-3. Certificate of authority required for operation of continuing care facilities.

Nothing in this title or chapter shall be deemed to authorize any provider of a continuing care facility or a facility providing limited continuing care to transact any insurance business other than that of continuing care insurance or limited continuing care insurance or otherwise to engage in any other type of insurance unless it is authorized under a certificate of authority issued by the department under this title. Nothing in this chapter shall be construed so as to interfere with the jurisdiction of the Department of Community Health or any other regulatory body exercising authority over continuing care providers or limited continuing care providers regulated by this chapter. (Code 1981, § 33-45-3, enacted by Ga. L. 1990, p. 1817, § 1; Ga. L. 1999, p. 296, § 22; Ga. L. 2000, p. 136, § 33; Ga. L. 2009, p. 453, § 1-43/HB 228; Ga. L. 2011, p. 315, § 1/SB 166.)

The 2009 amendment, effective July 1, 2009, deleted "the Department of Human Resources," following "jurisdiction of" and deleted a comma following "Community Health".

The 2011 amendment, effective July 1, 2011, in the first sentence, inserted "or

a facility providing limited continuing care" and "limited continuing care insurance or" near the middle, and added "or limited continuing care providers regulated by this chapter" at the end of the last sentence.

33-45-4. Administration by Insurance Department.

The administration of this chapter is vested in the department, which shall:

(1) Prepare and furnish all forms necessary under the provisions of this chapter;

(2) Collect in advance, and the applicant shall pay in advance at the time of filing, a fee for an application for a certificate of authority or a renewal of a certificate of authority, both as provided in Code Section 33-8-1, and a late fee to be determined by the department. The department may also levy a fine not to exceed \$50.00 a day for each day of noncompliance; and

(3) Adopt rules, within the standards of this chapter, necessary to effect the purposes of this chapter. Specific provisions in this chapter

relating to any subject shall not preclude the department from adopting rules concerning such subject if such rules are within the standards and purposes of this chapter. (Code 1981, § 33-45-4, enacted by Ga. L. 1990, p. 1817, § 1; Ga. L. 1992, p. 2725, § 32; Ga. L. 2005, p. 60, § 33/HB 95; Ga. L. 2011, p. 315, § 1/SB 166.)

The 2011 amendment, effective July 1, 2011, rewrote paragraph (2); substituted a period for a semicolon at the end of paragraph (3); and deleted paragraphs (4) and (5), which read: “(4) Adopt rules, within the standards of this chapter, to set a bond conditioned upon compliance with the provisions of this chapter. The amount of the bond shall be not less than

\$10,000.00. The rules adopted by the department shall provide for consideration of the obligations, financial condition, amounts of debt, service provisions, and such other features as deemed pertinent and applicable to the determination of a sufficient bond amount; and

“(5) Impose administrative fines and penalties pursuant to this chapter.”

33-45-5. Application for approval or renewal of certificate of authority.

No person may engage in the business of providing continuing care or limited continuing care or issuing continuing care agreements in this state without a certificate of authority therefor obtained from the department as provided in this chapter. For purposes of this Code section, the term “engage in the business of” shall include the development or construction of a facility subject to regulation under this chapter or the holding of oneself out to the public as a provider. The application for approval or renewal of a certificate of authority shall be on such forms as provided by the department. The department shall issue such certificate of authority if the applicant pays the required fees, and the continuing care agreement for the applicant meets the requirements of Code Section 33-45-7. The department shall renew a certificate of authority if the provider pays the required fees and furnishes the annual disclosure statement required by Code Section 33-45-6 and is otherwise not in violation of this chapter. (Code 1981, § 33-45-5, enacted by Ga. L. 1990, p. 1817, § 1; Ga. L. 2011, p. 315, § 1/SB 166; Ga. L. 2012, p. 775, § 33/HB 942.)

The 2011 amendment, effective July 1, 2011, inserted “limited continuing care or” in the first sentence, added the second sentence, substituted “fees,” for “fees” in the fourth sentence; and inserted “disclosure” in the last sentence.

The 2012 amendment, effective May 1, 2012, part of an Act to revise, modernize, and correct the Code, substituted “annual disclosure statement” for “annual disclosure statements” in this Code section.

33-45-6. Annual revised disclosure statement; statement to be made available to all residents of facility; submission of other necessary information as determined by Commissioner.

(a) Annually, on or before June 1, the provider shall file a revised disclosure statement and such other information and data showing its condition as of the last day of the preceding calendar year or fiscal year of the provider. If the department does not receive the required information on or before June 1, a late fee may be charged. The department may approve an extension of up to 30 days.

(b)(1) The provider shall also make the revised disclosure statement available to all the residents of the facility.

(2) A provider shall also revise its disclosure statement and have the revised disclosure statement recorded at any other time if revision is necessary to prevent an otherwise current disclosure statement from containing a material misstatement of fact or omitting a material fact required to be stated therein. Only the most recently recorded disclosure statement, with respect to a facility, and in any event, only a disclosure statement dated within one year plus 120 days prior to the due date of the time of renewal of a certificate of authority required by this chapter, shall be considered current.

(c) Notwithstanding the provisions of Code Section 33-45-9, the Commissioner may require a provider to submit such other information as he or she deems necessary to enforce this chapter. (Code 1981, § 33-45-6, enacted by Ga. L. 1990, p. 1817, § 1; Ga. L. 2011, p. 315, § 1/SB 166.)

The 2011 amendment, effective July 1, 2011, rewrote this Code section.

33-45-7. Requirements for continuing care agreements, addenda, and amendments.

(a) In addition to other provisions considered proper to effectuate any continuing care agreement, addendum, or amendment, each such agreement, addendum, or amendment shall be in writing and shall:

(1) Provide for the continuing care or limited continuing care of only one resident, or for two persons occupying space designed for double occupancy under appropriate regulations established by the provider, and shall state the total consideration to be paid, including a list of all properties transferred and their market value at the time of transfer, including donations, subscriptions, fees, and any other amounts paid or payable by, or on behalf of, the resident or residents;

(2) Specify all services which are to be provided by the provider to each resident, including, in detail, all items which each resident will receive, whether the items will be provided for a designated time period or for life, and whether the services will be available on the premises or at another specified location. The provider shall indicate which services or items are included in the monthly care fee and which services or items are made available at or by the facility at extra charge. Such items may include, but are not limited to, food, lodging, personal services or nursing care, drugs, burial, and incidentals;

(3) Describe the terms and conditions under which the continuing care agreement may be canceled by the provider or by a resident and the conditions, if any, under which all or any portion of the entrance fee will be refunded in the event of cancellation of the continuing care agreement by the provider or by the resident, including the effect of death of or any change in the health or financial condition of a person between the date of entering a continuing care agreement and the date of initial occupancy of a residential unit by that person;

(4) Describe:

(A) The residential unit;

(B) Any property rights of the resident;

(C) The health and financial conditions required for a person to be accepted as a resident and to continue as a resident, once accepted, including the effect of any change in the health or financial condition of a person between the date of entering into a continuing care agreement and the date of taking occupancy in a residential unit;

(D) The conditions under which a residential unit occupied by a resident may be made available by the provider to a different or new resident other than on the death of the prior resident;

(E) The policies to be implemented and the circumstances under which the resident will be permitted to remain in the facility in the event of financial difficulties of the resident; and

(F) The procedures the provider shall follow to change the resident's accommodation if necessary for the protection of the health or safety of the resident or of the general and economic welfare of the facility;

(5) State the fees that will be charged if the resident marries while at the designated facility, the terms concerning the entry of a spouse to the facility, and the consequences if the spouse does not meet the requirements for entry;

(6) State whether the funds or property transferred for the care of the resident is:

(A) Nonrefundable, in which event the continuing care agreement shall comply with this subparagraph. Such continuing care agreement shall allow a 90 day trial period of residency in the facility during which time the provider, resident, or person who provided the transfer of funds or property for the care of such resident may cancel the agreement after written notice. A refund shall be made of such funds, property, or both within 120 days after the receipt of such notice and shall be calculated on a pro rata basis with the provider retaining no more than 10 percent of the amount of the entry fee. Notwithstanding the provisions of this subparagraph, the provisions of paragraph (7) of this subsection and the provisions of subsections (b) and (e) of this Code section shall apply to nonrefundable continuing care agreements; or

(B) Refundable, in which event the continuing care agreement shall comply with this subparagraph. Such continuing care agreement may be canceled upon the giving of written notice of cancellation of at least 30 days by the provider, the resident, or the person who provided the transfer of property or funds for the care of such resident; provided, however, that if a continuing care agreement is canceled because there has been a good faith determination that a resident is a threat to his or her health or safety or to the health or safety of others, only such notice as is reasonable under the circumstances shall be required. The continuing care agreement shall further provide in clear and understandable language, in print no smaller than the largest type used in the body of the continuing care agreement, the terms governing the refund of any portion of the entrance fee, which terms shall include a provision that all refunds be made within 120 days of notification. The moneys refunded to the resident may be from the escrow account required by Code Section 33-45-8 or from other funds available to the provider, and the continuing care agreement shall further comply with the following requirements:

(i) For a resident whose continuing care agreement with the facility provides that the resident does not receive a transferable membership or ownership right in the facility and who has occupied his or her residential unit, the refund shall be calculated on a pro rata basis with the facility retaining no more than 2 percent per month of occupancy by the resident and no more than a 4 percent fee for processing. Such refund shall be paid no later than 120 days after the giving of notice of intention to cancel; or

(ii) If the continuing care agreement provides for the facility to retain no more than 1 percent per month of occupancy by the

resident, it may provide that such refund will be payable upon receipt by the provider of the next entrance fee for any comparable residential unit upon which there is no prior claim by any resident; provided, however, that the agreement may define the term "comparable residential unit upon which there is no prior claim"; specifically delineate when such refund is due; and establish the order of priority of refunds to residents. Unless the provisions of subsection (e) of this Code section apply, for any prospective resident, regardless of whether or not such resident receives a transferable membership or ownership right in the facility, who cancels the agreement prior to occupancy of the residential unit, the refund shall be the entire amount paid toward the entrance fee, less a processing fee not to exceed 4 percent of the entire entrance fee, but in no event shall such processing fee exceed the amount paid by the prospective resident. Such refund shall be paid no later than 60 days after the giving of notice of intention to cancel. For a resident who has occupied his or her residential unit and who has received a transferable membership or ownership right in the facility, the foregoing refund provisions shall not apply but shall be deemed satisfied by the acquisition or receipt of a transferable membership or an ownership right in the facility. The provider shall not charge any fee for the transfer of membership or sale of an ownership right. Nothing in this paragraph shall be construed to require a continuing care agreement to provide a refund to more than one resident at a time upon the vacation of a specific comparable residential unit;

(7) State the terms under which a continuing care agreement is canceled by the death of the resident. These terms may contain a provision that, upon the death of a resident, the entrance fee of such resident shall be considered earned and shall become the property of the provider. When the unit is shared, the conditions with respect to the effect of the death or removal of one of the residents shall be included in the continuing care agreement;

(8) Require:

(A) The continuing care agreement to provide for advance notice to the resident, of not less than 60 days, before any change in fees or charges or the scope of care or services may be effective, except for changes required by state or federal assistance programs;

(B) A description of the manner by which the provider may adjust periodic charges or other recurring fees and the limitations on these adjustments, if any; and

(C) A description of any policy regarding fee adjustments if the resident is voluntarily absent from the facility;

(9) Provide that charges for care paid in one lump sum shall not be increased or changed during the duration of the agreed upon care, except for changes required by state or federal assistance programs; and

(10) Describe the policy of the provider regarding reserve funding.

(b) Notwithstanding the provisions of subparagraph (a)(6)(A) of this Code section, a resident has the right to rescind a continuing care agreement, without penalty or forfeiture, within seven days after executing such continuing care agreement. During the seven-day period, the resident's funds shall be retained in an escrow account in accordance with the provisions of subsection (a) of Code Section 33-45-8. A resident shall not be required to move into the facility designated in the continuing care agreement before the expiration of the seven-day period. In the event that the prospective resident exercises his or her right to rescind the continuing care agreement within seven days of executing such continuing care agreement, the facility shall return any portion of the entrance fee paid by the resident within 30 days of receipt of the prospective resident's notice of rescission.

(c) The continuing care agreement shall include or shall be accompanied by a statement, printed in boldface type, which reads: "This facility and all continuing care agreements in this state are regulated by Chapter 45 of Title 33 of the Official Code of Georgia Annotated. A copy of the law is on file in this facility. The law gives you or your legal representative the right to inspect our most recent disclosure statement before signing the agreement."

(d) Before the transfer of any money or other property, other than an application fee which shall not exceed \$1,500.00, to a provider by or on behalf of a prospective resident, the provider shall present a typewritten or printed copy of the continuing care agreement and the disclosure statement required pursuant to Code Section 33-45-10 to the prospective resident and all other parties to the agreement. The provider shall secure a signed, dated statement from each party to the contract certifying that a copy of the continuing care agreement and the disclosure statement was received.

(e) If a resident dies before occupying the facility or, through illness, injury, or incapacity, is precluded from becoming a resident under the terms of the continuing care agreement, the agreement shall be automatically canceled, and the resident or his or her legal representative shall receive a full refund of all moneys paid to the facility, except those costs specifically incurred by the facility at the request of the resident and set forth in writing in a separate addendum, signed by both parties, to the agreement.

(f) In order to comply with this Code section, a provider may furnish information not contained in the continuing care agreement through an addendum.

(g) The Commissioner may also require the provider to submit to him or her a copy of the continuing care agreement generally used by the provider; provided, however, that nothing in this subsection shall prohibit the department from requiring the submission of an individual contract between the provider and the resident. (Code 1981, § 33-45-7, enacted by Ga. L. 1990, p. 1817, § 1; Ga. L. 2011, p. 315, § 1/SB 166; Ga. L. 2012, p. 775, § 33/HB 942.)

The 2011 amendment, effective July 1, 2011, rewrote this Code section.

The 2012 amendment, effective May 1, 2012, part of an Act to revise, modern-

ize, and correct the Code, substituted “a list of all properties” for “a list all properties” in paragraph (a)(1).

33-45-8. Portion of entrance fee paid by resident to be held in escrow account.

(a) Any portion of the entrance fee paid by a resident to the provider shall be held in an escrow account. The escrow agreement shall state that its purpose is to protect the resident or the prospective resident. Escrow funds may be released to the resident, prospective resident, or provider in accordance with the provisions of this Code section.

(b) Entrance fees placed in escrow may be released in accordance with the provisions of this subsection as follows:

(1) Escrow funds may be released to the resident during or following the seven-day right of rescission period required in subsection (b) of Code Section 33-45-7. Such release shall be in accordance with the provisions of that Code section;

(2) When a continuing care agreement between a resident and provider is nonrefundable, escrow funds or a portion thereof may be released to the resident if the resident exercises his or her right to receive a refund as provided in subparagraph (a)(6)(A) of Code Section 33-45-7. The amount and timing of the release of funds to the resident shall be in compliance with the provisions of that subparagraph;

(3) When the continuing care agreement between a provider and resident or prospective resident is refundable, escrow funds may be released by the provider to such resident or prospective resident. The amount and timing of the release of funds to the resident shall be in compliance with the provisions of subparagraph (a)(6)(B) of Code Section 33-45-7;

(4) For a facility under construction or in development, escrow funds may be released to the provider when:

(A) The provider has presold at least 50 percent of the residential units, having received a minimum 10 percent deposit on each of the presold residential units;

(B) The provider has received a commitment for any first mortgage loan or other financing, and any conditions of the commitment prior to disbursement of funds thereunder have been substantially satisfied; and

(C) Aggregate entrance fees received or receivable by the provider pursuant to binding continuing care agreements, plus the anticipated proceeds of any first mortgage loan or other financing commitment, are equal to not less than 90 percent of the aggregate cost of constructing or purchasing, equipping, and furnishing the facility, and not less than 90 percent of the funds estimated in the statement of cash flows submitted by the provider as that part of the disclosure statement required by this chapter, to be necessary to fund start-up losses and assure full performance of the obligations of the provider pursuant to continuing care contracts shall be on hand;

(5) At the time a new project is financed or after the opening of a facility by a provider, escrow funds may be released to the provider, so long as the provider is in compliance with the financial reserves required by Code Section 33-45-11 and sufficient funds are maintained in escrow to meet the provider's obligations under subparagraphs (1) and (2) of this subsection; or

(6) Escrow funds may be released to the provider under terms submitted to and approved by the Commissioner. (Code 1981, § 33-45-8, enacted by Ga. L. 2011, p. 315, § 1/SB 166; Ga. L. 2012, p. 775, § 33/HB 942.)

Effective date. — This Code section became effective July 1, 2011.

The 2012 amendment, effective May 1, 2012, part of an Act to revise, modernize, and correct the Code, substituted “subparagraph (a)(6)(A)” for “subparagraph (A) of paragraph (6) of subsection (a)” in paragraph (b)(2) and substituted

“subparagraph (a)(6)(B)” for “subparagraph (B) of paragraph (6) of subsection (a)” in paragraph (b)(3).

Editor's notes. — Ga. L. 2011, p. 315, § 1, effective July 1, 2011, redesignated former Code Section 33-45-8 as present Code Section 33-45-9.

33-45-9. Provisions of this chapter not subject to waiver.

No act, agreement, or statement of any resident, or of an individual purchasing continuing care or limited continuing care for a resident, under any continuing care agreement to furnish care to the resident shall constitute a valid waiver of any provision of this chapter intended for the benefit or protection of the resident or the individual purchasing care for the resident; provided, however, that nothing in this Code

section shall be construed to prohibit a continuing care agreement from providing for a resident or prospective resident to agree to arbitration prior to bringing any action pursuant to Code Section 33-45-12. (Code 1981, § 33-45-8, enacted by Ga. L. 1990, p. 1817, § 1; Code 1981, § 33-45-9, as redesignated by Ga. L. 2011, p. 315, § 1/SB 166.)

The 2011 amendment, effective July 1, 2011, redesignated former Code Section 33-45-8 as present Code Section 33-45-9, and inserted “continuing care or limited continuing” and “continuing care” near the beginning, and added the proviso at the end.

Editor’s notes. — Ga. L. 2011, p. 315, § 1, effective July 1, 2011, redesignated former Code Section 33-45-9 as present Code Section 33-45-10.

33-45-10. Information disclosure requirements.

(a) Each facility shall maintain as public information, available upon request, a copy of its current disclosure statement and the disclosure and all previous disclosure statements that have been filed with the department.

(b) Each facility shall post in a prominent position in the facility so as to be accessible to all residents and to the general public a brief summary of the disclosure statement required pursuant to subsection (a) of this Code section, indicating in the summary where the full disclosure statement may be inspected in the facility. A listing of any proposed changes in policies, programs, and services shall also be posted.

(c) Before entering into a continuing care agreement to furnish continuing care or at the time of, or prior to, the transfer of any money or other property to a provider by or on behalf of a prospective resident, whichever occurs first, the provider undertaking to furnish the care, or the agent of the provider, shall provide the current disclosure statement required pursuant to subsection (a) of this Code section and copies to the prospective resident, or his or her legal representative, of the continuing care agreement.

(d) The text of the disclosure statement required by this Code section shall contain at least:

(1) The name and business address of the provider and a statement as to whether the provider is a partnership, corporation, or other type of legal entity;

(2) The names and business addresses and description of the business experience of the person, if any, in the operation or management of similar facilities of the officers, directors, trustees, managing or general partners, any person having a 10 percent or greater equity or beneficial interest in the provider, and any person who will

be managing the facility on a day to day basis and a description of these persons' interests in or occupations with the provider;

(3) Information on all persons named in response to paragraph (2) of this subsection which details:

(A) Any conflict or potential conflict of interest; and

(B) Any relevant criminal record, including a plea of nolo contendere, background on relevant civil judicial proceedings, and relevant action brought by a governmental agency or department, if the order or action arose out of or related to business activity of health care;

(4) A statement as to whether the provider is or is not affiliated with a religious, charitable, or other nonprofit organization; the extent of the affiliation, if any; the extent to which the affiliate organization will be responsible for the financial and contract obligations of the provider; and the provision of the Federal Internal Revenue Code, if any, under which the provider or affiliate is exempt from the payment of income tax;

(5) An estimate of the number of residents of the facility to be provided services;

(6) The location and description of the physical property or properties of the facility, existing or proposed, and to the extent proposed, the estimated completion date or dates, whether construction has begun, and the contingencies subject to which construction may be deferred;

(7) The location of other facilities, if any, which the provider owns or operates;

(8) A statement that the provider maintains financial reserves in conformance with the requirements of Code Section 33-45-11 or otherwise meets the requirements of that Code section; the provisions that the provider has made or will make to provide reserve funding or security to enable the provider to perform its obligations fully under continuing care agreements to provide continuing care or limited continuing care at the facility, including the establishment of escrow accounts, trusts, or reserve funds, together with the manner in which these funds will be invested; and the names and experience of any individuals in the direct employment of the provider who will make the investment decisions;

(9) A financial statement audited by an independent certified public accountant which shall provide the information required by this Code section for two or more fiscal years if the facility has been in existence that long. If the facility has been in existence for a lesser

length of time, the financial statements of the provider shall be for the most recent fiscal year or such shorter period of time as the provider shall have been in existence. If the provider's fiscal year ended more than 120 days prior to the date the disclosure statement is recorded, interim financial statements as of a date not more than 90 days prior to the date of recording the statement shall also be included but need not be certified to by an independent certified public accountant. The financial statement shall contain the following:

(A) An accountant's opinion and, in accordance with generally accepted accounting principles:

- (i) A balance sheet;
- (ii) A statement of income and expenses;
- (iii) A statement of equity or fund balances; and
- (iv) A statement of changes in financial position; and

(B) Notes to the financial statements considered customary or necessary for full disclosure or adequate understanding of the financial statements, financial condition, and operation and additional costs to the resident;

(10) The level of participation in medicare or Medicaid programs, or both; and

(11) A statement concerning all fees required of residents, including, but not limited to:

(A) A statement of the entrance fee charged, the monthly service charges, the proposed application of the proceeds of the entrance fee by the provider, and the plan by which the amount of the entrance fee is determined if the entrance fee is not the same in all cases; and

(B) A record of past increases in entrance fees and monthly care fees and other similar charges during the previous three years;

(12) If a facility is in a stage of being proposed or developed, it shall additionally provide:

(A) The summary of the report of an actuary estimating the capacity of the provider to meet its contractual obligation to the residents; and

(B) A statement of cash flows and narrative disclosure detailing all significant assumptions used in the preparation of the statement of cash flows. The Commissioner may establish by rule or regulation the necessary and significant assumptions used in the preparation of the statements of cash flow; and

(13) Any additional costs to the resident.

(e) The cover page of the disclosure statement shall state, in a prominent location and in boldface type, the date of the disclosure statement, the last date through which the disclosure statement may be delivered if not earlier revised, and that the delivery of the disclosure statement to a contracting party before the execution of a continuing care agreement is required by this chapter, but that the disclosure statement has not been reviewed or approved by any government agency or representative to ensure accuracy or completeness of the information set out.

(f) A copy of the continuing care agreement generally used by the provider shall be attached to each disclosure statement.

(g) The Commissioner may prescribe a standardized format for the disclosure statement required by this Code section.

(h) The department may require a provider to alter or amend its disclosure statement in order to provide full and fair disclosure to prospective residents. The department may also require the revision of a disclosure statement which it finds to be unnecessarily complex, confusing, or illegible. (Code 1981, § 33-45-9, enacted by Ga. L. 1990, p. 1817, § 1; Code 1981, § 33-45-10, as redesignated by Ga. L. 2011, p. 315, § 1/SB 166.)

The 2011 amendment, effective July 1, 2011, redesignated former Code Section 33-45-9 as present Code Section 33-45-10, and rewrote this Code section.

Editor's notes. — Ga. L. 2011, p. 315, § 1, effective July 1, 2011, redesignated former Code Section 33-45-10 as present Code Section 33-45-13.

33-45-11. Maintaining financial reserves; requirements.

(a) A provider or facility shall maintain financial reserves equal to 25 percent of the total operating costs of the facility projected for the 12 month period following the period covered by the most recent audited financial statements included in the disclosure statement required by Code Section 33-45-10. In addition to total operating expenses, total operating costs shall include debt service, consisting of principal and interest payments, along with taxes and insurance on any mortgage loan or other financing, but shall exclude depreciation, amortized expenses, and extraordinary items as approved by the Commissioner. If the debt service portion is accounted for by way of another reserve account, the debt service portion may be excluded.

(b) A provider or facility which has opened but not yet achieved full occupancy, as defined by its lender or financing documents, if any, or 95 percent occupancy of its residential units; or a provider or facility that has received a certificate of authority and has been in conformance with the provisions of this chapter prior to July 1, 2011, shall be required to

achieve the level of financial reserves required by paragraph (1) of this subsection as follows:

(1) The provider or facility shall submit a plan to the Commissioner the terms of which assure that the provider or facility shall maintain sufficient progress to achieving the level of financial reserves required by this Code section; and

(2) The plan demonstrates that the provider or facility is substantially likely to achieve the required level of financial reserves within five years of opening or for existing facilities that received a certificate of authority and have been in conformance with the provisions of this chapter prior to July 1, 2011, within five years of July 1, 2011. For purposes of this paragraph, the term "substantially likely" means a provider or facility shall meet the level of financial reserves required by paragraph (1) of this subsection at a minimum rate of 20 percent per year as of the end of each fiscal year after the later of the date the facility opens or July 1, 2011, up to a total of 100 percent as of the end of the fifth fiscal year.

(c) The financial reserves required by this Code section may be funded by cash, by invested cash, or by investment grade securities, including bonds, stocks, United States Treasury obligations, obligations of United States government agencies, any reserves required by lenders or established by the facility, or any other financial resources approved by the Commissioner that can be used by the facility to meet its operating reserve.

(d) The provider or facility shall notify the Commissioner as soon as the provider or facility has knowledge of the need to expend any funds which reduce the balance in the financial reserves to an amount less than the amount required by this Code section. Such notice shall be made within at least 30 business days of the provider or facility having such knowledge. If the provider or facility does not have such knowledge within 30 business days, the provider or facility shall notify the Commissioner as soon as possible, but not more than 30 business days after the expenditure of such funds. In the event that the amount in the reserves falls to an amount less than the amount required by this Code section, the Commissioner:

(1) Shall require that the provider or facility submit a corrective action plan to be approved by the department such that the Commissioner finds that the provider or facility can be reasonably expected to be able to reinstate the level of financial reserves required by this Code section within sufficient time to ensure that the contractual liabilities of the provider and the best interests of the residents of the facility will be adequately protected; and

(2) May require the provider or facility to make additional financial arrangements to ensure that the contractual liabilities of the

provider and the best interests of the residents of the facility are adequately protected. Such arrangements may include:

(A) The posting of a security bond;

(B) Requiring that the proceeds from any entrance fees from new residents be placed in escrow. Any requirement to escrow funds shall not be applied to funds which are subject to prior claims by a resident of the facility;

(C) Any other security which the Commissioner determines provides adequate assurance that the provider or facility will be able to fulfill its obligations to its residents to the same extent as it would be if the financial reserves were funded at the amount required by this Code section; or

(D) Requiring the provider or facility to work with lenders to refinance or reevaluate the current debt of the provider or facility.

(e) Upon written application by a provider, the Commissioner may authorize a facility to maintain financial reserves in an amount less than the amount set forth in this Code section, or at a lesser rate than the minimum rate of 20 percent per year as of the end of each fiscal year set forth in paragraph (2) of subsection (b) of this Code section, if the Commissioner determines that the contractual liabilities of the provider and the best interests of the residents of the facility may be adequately protected by the financial reserves in a lesser amount or by achieving the required financial reserves at a lesser rate than 20 percent per year. (Code 1981, § 33-45-11, enacted by Ga. L. 2011, p. 315, § 1/SB 166.)

Effective date. — This Code section § 1, effective July 1, 2011, redesignated became effective July 1, 2011. former Code Section 33-45-11 as present

Editor's notes. — Ga. L. 2011, p. 315, Code Section 33-45-12.

33-45-12. Actions for recovery of damages and attorney's fees.

Any resident injured by a violation of this chapter may bring an action for the recovery of damages plus reasonable attorney's fees. (Code 1981, § 33-45-11, enacted by Ga. L. 1990, p. 1817, § 1; Code 1981, § 33-45-12, as redesignated by Ga. L. 2011, p. 315, § 1/SB 166.)

The 2011 amendment, effective July 1, 2011, redesignated former Code Section 33-45-11 as present Code Section 33-45-12.

Editor's notes. — Ga. L. 2011, p. 315, § 1, effective July 1, 2011, redesignated former Code Section 33-45-12 as present Code Section 33-45-14.

33-45-13. Penalties for violation of chapter provisions; department authorized to take remedial action, including suspension and revocation of certificate of authority.

(a) Any person who knowingly maintains, enters into, performs, or, as manager or officer or in any other administrative capacity, assists in entering into, maintaining, or performing any continuing care agreement subject to this chapter without a valid certificate of authority or renewal thereof, as contemplated by or provided in this chapter, or who otherwise violates any provision of this chapter, is guilty of a misdemeanor. Each violation of this chapter constitutes a separate offense.

(b) In addition to the powers granted pursuant to Chapters 1 and 2 of this title, the department may bring an action to enjoin a violation, threatened violation, or continued violation of this chapter in the superior court of the county in which the violation occurred, is occurring, or is about to occur.

(c) If, after a period of 180 days, or such additional time as the department shall deem appropriate, the corrective action plan required by paragraph (1) of subsection (d) of Code Section 33-45-11 has been submitted and approved by the department and the department deems the facility or provider to be unable to achieve the necessary financial reserves or is not making substantial progress toward achieving the required financial reserves, the department shall be authorized to take immediate action against the facility or provider's certificate of authority, including suspension or revocation of the certificate of authority; provided, however, that before the Commissioner suspends or revokes a certificate of authority, the Commissioner shall conduct a hearing in accordance with Chapter 2 of this title.

(d) Any action brought by the department against a provider shall not abate by reason of a sale or other transfer of ownership of the facility used to provide care, which provider is a party to the action, except with the express written consent of the Commissioner. (Code 1981, § 33-45-10, enacted by Ga. L. 1990, p. 1817, § 1; Code 1981, § 33-45-13, as redesignated by Ga. L. 2011, p. 315, § 1/SB 166.)

The 2011 amendment, effective July 1, 2011, redesignated former Code Section 33-45-10 as present Code Section 33-45-13; substituted "In addition to the powers granted pursuant to Chapters 1 and 2 of this title, the" for "The" in subsec-

tion (b); added present subsection (c); redesignated former subsection (c) as present subsection (d); and, in subsection (d), deleted "of Insurance" following "the Commissioner" at the end.

33-45-14. Period of applicability of chapter.

Any contract or continuing care agreement executed before July 1, 1991, which is amended or renewed subsequent to July 1, 1991, and any

contract or continuing care agreement executed on or after July 1, 1991, shall be subject to this chapter. (Code 1981, § 33-45-12, enacted by Ga. L. 1990, p. 1817, § 1; Code 1981, § 33-45-14, as redesignated by Ga. L. 2011, p. 315, § 1/SB 166.)

The 2011 amendment, effective July 1, 2011, redesignated former Code Section 33-45-12 as present Code Section 33-45-14; in this Code section, substituted “contract or continuing care agreement” for “contract or agreement for continuing care”, and substituted “or continuing care agreement” for “or agreement for continuing care”, and substituted “shall be subject” for “is subject” near the end.

CHAPTER 47

MANAGING GENERAL AGENTS

Sec.
33-47-4.1. Fully earned policy fees.

33-47-4.1. Fully earned policy fees.

No licensed managing general agent may charge a fully earned policy fee in connection with the issuance of an insurance policy unless such fee shall be a component of the insurer’s rate filing. No fully earned policy fee may exceed \$25.00. (Code 1981, § 33-47-4.1, enacted by Ga. L. 2009, p. 616, § 3/SB 144.)

Effective date. — This Code section became effective July 1, 2009.

CHAPTER 50

MULTIPLE EMPLOYER SELF-INSURED HEALTH PLANS

Sec.		Sec.	
33-50-2.	License required to transact business; health plans of municipalities, counties, or other political subdivisions.		quirements; security deposit; annual audit; aggregate excess stop-loss coverage; individual excess stop-loss coverage.
33-50-3.	Application for license; payment of fees; payment of premium taxes.	33-50-6.	Requirements for holding of funds collected.
33-50-5.	Minimum surplus; capital re-	33-50-7.	Required disclosure statements.

Sec.
33-50-14. Commissioner approval of
plans offering coverage in
other states.

33-50-2. License required to transact business; health plans of municipalities, counties, or other political subdivisions.

(a) It is unlawful for any multiple employer self-insured health plan to transact business in this state without a license issued by the Commissioner. Any of the acts described as the transaction of insurance in Code Section 33-1-2, effected by mail or otherwise, by or on behalf of a multiple employer self-insured health plan constitutes the transaction of business in this state. Any multiple employer self-insured health plan which transacts business in this state without the license required by this chapter shall be considered to be an unauthorized insurer within the meaning of Chapter 5 of this title and all remedies and penalties prescribed in such chapter shall be fully applicable.

(b) This chapter does not apply to any plan or arrangement established or maintained by municipalities, counties, or other political subdivisions of this state; any multiple employer self-insured health plan which is not subject to the application of state insurance laws under the provisions of the Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq.; to organizations established under the authority of or receiving funds pursuant to 42 U.S.C. Section 254(b) or 254(c), the federal Public Health Service Act; any other nonprofit organization exempt from federal taxation whose primary purpose is providing access to primary health care services for indigent citizens of Georgia; any plan or arrangement established or maintained by a nonprofit educational organization with assets of more than \$100 million for the benefit of the employees of such organization and the employees of any affiliated or associated persons, firms, associations, or corporations which perform functions related to those of such educational organization or of which a majority of the membership of the governing body is composed of employees or members of the governing body of the nonprofit educational organization; or to any plan or arrangement established or maintained, directly or through a legal entity, by two or more accredited independent nonproprietary institutions of higher education located in this state that have combined assets of more than \$100 million and are members of the Georgia nonprofit corporation representing a majority of the accredited independent nonproprietary institutions of higher education located in this state for the benefit of the employees, including retired employees, of:

- (1) Such institutions;

(2) Any affiliated or associated persons, firms, associations, trusts, or corporations that perform functions similar or related to those of one or more of such institutions or of which a majority of the membership of the governing body is composed of employees or members of the governing body of one or more of such institutions; and

(3) The Georgia nonprofit corporation representing a majority of the accredited independent nonproprietary institutions of higher education located in this state. (Code 1981, § 33-50-2, enacted by Ga. L. 1991, p. 1021, § 1; Ga. L. 1993, p. 329, § 1; Ga. L. 2009, p. 724, § 1/SB 63.)

The 2009 amendment, effective July 1, 2009, in subsection (b), substituted “this state” for “the state” near the beginning, deleted “or to” preceding “any plan” near the middle, added “; or to any plan or arrangement established or maintained, directly or through a legal entity, by two or more accredited independent nonproprietary institutions of higher education lo-

cated in this state that have combined assets of more than \$100 million and are members of the Georgia nonprofit corporation representing a majority of the accredited independent nonproprietary institutions of higher education located in this state for the benefit of the employees, including retired employees, of:”, and added paragraphs (b)(1) through (b)(3).

33-50-3. Application for license; payment of fees; payment of premium taxes.

(a) Application for a license shall be made on forms prescribed by the Commissioner.

(b) Every multiple employer self-insured health plan shall pay to the Commissioner annual license fees, as established by rule or regulation of the Commissioner.

(c) Every multiple employer self-insured health plan shall pay to the Commissioner the premium taxes on the plan’s net retained premium after deducting premium paid by the plan to its excess insurer and any other applicable deductions provided for in Chapter 8 of this title. The applicable premium tax rate shall be the applicable rates for insurance companies provided for in Chapter 8 of this title. (Code 1981, § 33-50-3, enacted by Ga. L. 1991, p. 1021, § 1; Ga. L. 2010, p. 757, § 2/SB 310; Ga. L. 2011, p. 752, § 33/HB 142.)

The 2010 amendment, effective July 1, 2010, in subsection (a), substituted “shall” for “must” near the beginning, and deleted the last sentence, which read: “No multiple employer self-insured health plan may be licensed unless it has and maintains a minimum of 250 covered employees.”; in subsection (c), substituted the present provisions for the former pro-

visions, which read: “Every multiple employer self-insured health plan shall pay to the Commissioner the premium taxes required for insurance companies as set forth in Chapter 8 of this title.”; and deleted subsection (d), which read: “The Commissioner shall establish, by rule or regulation, security deposits for multiple employer self-insured health plans.”

The 2011 amendment, effective May 13, 2011, part of an Act to revise, modernize, and correct the Code, substituted “Chapter 8 of this title” for “Chapter 8 of Title 33” twice in subsection (c).

33-50-5. Minimum surplus; capital requirements; security deposit; annual audit; aggregate excess stop-loss coverage; individual excess stop-loss coverage.

(a) No multiple employer self-insured health plan shall be licensed unless it shall possess and thereafter maintain a minimum surplus of at least \$200,000.00.

(b) A multiple employer self-insured health plan shall be subject to and comply with the applicable regulatory action level risk-based capital requirements prescribed by Chapter 56 of this title.

(c) Every multiple employer self-insured health plan shall maintain a security deposit with the Commissioner. The amount of the deposit shall be \$100,000.00 and shall be in the form of securities eligible for the investment of capital funds of domestic insurers. The deposit shall be administered in accordance with the provisions of Chapter 12 of this title.

(d) Every multiple employer self-insured health plan shall annually obtain an opinion from a qualified actuary as to the adequacy of its loss reserves. Such opinion shall be prepared and issued based on standards adopted from time to time by the Actuarial Standards Board and in accordance with instruction prescribed by the National Association of Insurance Commissioners.

(e) Every multiple employer self-insured health plan licensed pursuant to this chapter shall have an annual audit by an independent certified public accountant in accordance with Georgia Insurance Department Regulation 120-2-60 and instructions prescribed by the National Association of Insurance Commissioners.

(f) Every multiple employer self-insured health plan shall file financial statements with the Commissioner in accordance with the provisions of Georgia Insurance Department Regulation 120-2-18-.06.

(g)(1) Every multiple employer self-insured health plan shall obtain and thereafter maintain aggregate excess stop-loss coverage and individual excess stop-loss coverage.

(2) Excess stop-loss coverage required by this Code section shall be issued by an insurer licensed by the state.

(3) The retention limits for both the aggregate excess stop-loss coverage and individual excess stop-loss coverage shall be determined annually by a qualified actuary based on sound actuarial principles.

(4) Any stop-loss contract maintained pursuant to this Code section shall contain a provision that the stop-loss insurer shall give the multiple employer self-insured health plan and the Commissioner a minimum of 180 days' notice of cancellation or nonrenewal.

(5) If the multiple employer self-insured health plan fails to obtain replacement coverage within 90 days after receipt of the notice of cancellation or nonrenewal, the trustees of the plan shall provide for the orderly liquidation of the multiple employer self-insured health plan.

(h)(1) Each participating employer shall be jointly and severally liable for all legal obligations of the multiple employer self-insured health plans created on or after July 1, 2010.

(2) If the assets of the multiple employer self-insured health plan are at any time insufficient to enable the plan to discharge its legal liabilities and other obligations and to maintain the surplus required under this Code section, it shall forthwith make up the deficiency or levy an assessment upon its participating employers for the amount needed to make up the deficiency.

(3) If the multiple employer self-insured health plan fails to make up the deficiency or make the required assessment within 30 days after the Commissioner orders it to do so or if the deficiency is not fully made up within 60 days after the date on which any such assessment is made or within such longer period as may be specified by the Commissioner, the plan shall be deemed to be insolvent.

(4) If the liquidation of a multiple employer self-insured health plan is ordered, an assessment shall be levied upon its participating employers for such an amount as the Commissioner determines to be necessary to discharge all liabilities of the plan, including the reasonable costs of liquidation.

(i) A multiple employer self-insured health plan licensed before January 1, 2010, shall have until December 31, 2011, to comply with the provisions of this Code section. (Code 1981, § 33-50-5, enacted by Ga. L. 1991, p. 1021, § 1; Ga. L. 2010, p. 757, § 3/SB 310; Ga. L. 2011, p. 752, § 33/HB 142.)

The 2010 amendment, effective July 1, 2010, rewrote this Code section.

The 2011 amendment, effective May 13, 2011, part of an Act to revise, modernize, and correct the Code, redesignated the introductory language of subsection (g) as present paragraph (g)(1), and redesignated former paragraphs (g)(1) through

(g)(4) as present paragraphs (g)(2) through (g)(5), respectively; and redesignated the introductory language of subsection (h) as present paragraph (h)(1), and redesignated former paragraphs (h)(1) through (h)(3) as present paragraphs (h)(2) through (h)(4), respectively.

33-50-6. Requirements for holding of funds collected.

Funds collected from the participating employers under multiple employer self-insured health plans shall be held in trust subject to the following requirements:

(1) A board of trustees elected by participating employers shall serve as fund managers on behalf of participants. Trustees shall be plan participants or be an employee or owner of a participating employer or an employee of a sponsoring association. No participating employer shall be represented by more than one trustee. A minimum of three and a maximum of seven trustees may be elected. Trustees shall not receive remuneration but they may be reimbursed for actual and reasonable expenses incurred in connection with duties as trustee;

(2) Trustees shall be bonded in an amount not less than \$150,000.00 from a licensed surety company or covered under a directors and officers liability policy issued to the multiple employer self-insured health plan;

(3) Investment of plan funds shall be subject to the same restrictions which are applicable to insurers as provided in Chapter 11 of this title; and

(4) A multiple employer self-insured health plan shall maintain a minimum loss ratio of at least 70 percent. Compliance with such minimum loss ratio standard shall be evaluated annually by a multiple employer self-insured health plan. Failure to comply with minimum loss ratio standards shall result in a premium refund to participating employers. (Code 1981, § 33-50-6, enacted by Ga. L. 1991, p. 1021, § 1; Ga. L. 2010, p. 757, § 4/SB 310.)

The 2010 amendment, effective July 1, 2010, substituted “shall” for “must” throughout this Code section; in paragraph (1), added “or be an employee or owner of a participating employer or an employee of a sponsoring association” at the end of the second sentence and substituted “shall” for “may” in the third and

fourth sentences; in paragraph (2), added “or covered under a directors and officers liability policy issued to the multiple employer self-insured health plan” at the end; in paragraph (3), substituted “shall be” for “is” near the beginning; and rewrote paragraph (4).

33-50-7. Required disclosure statements.

Every application for benefits and every benefit plan issued by a multiple employer self-insured health plan shall contain in contrasting color, in not less than ten-point type, the following statements:

(1) The plan is a self-insured plan, and benefits are not guaranteed by a licensed insurer;

(2) The plan is not covered by the Georgia Life and Health Guaranty Association;

(3) This is a fully assessable benefit plan. In the event that the multiple employer self-insured health plan is unable to pay its obligations, participating employers shall be required to contribute on a joint and several basis the funds necessary to meet any unpaid obligations; and

(4) Certain other major protections offered to Georgia residents under the Georgia Insurance Code and Rules and Regulations, such as conversion rights and certain mandated or required benefits, may not be available through the multiple employer self-insured plan. (Code 1981, § 33-50-7, enacted by Ga. L. 1991, p. 1021, § 1; Ga. L. 2010, p. 757, § 5/SB 310.)

The 2010 amendment, effective July 1, 2010, rewrote this Code section.

33-50-14. Commissioner approval of plans offering coverage in other states.

A multiple employer self-insured health plan which covers lives in other states may cover lives in this state only if the Commissioner deems the plan to be in compliance with the requirements of this chapter. (Code 1981, § 33-50-14, enacted by Ga. L. 2010, p. 757, § 6/SB 310; Ga. L. 2011, p. 752, § 33/HB 142.)

Effective date. — This Code section 13, 2011, part of an Act to revise, modernize, and correct the Code, revised punctuation in this Code section.
The 2011 amendment, effective May

CHAPTER 51

GEORGIA AFFORDABLE HSA ELIGIBLE HIGH DEDUCTIBLE HEALTH PLAN

Sec.		Sec.	
33-51-1.	Short title.	33-51-5.	Nonpreferred provider reimbursement.
33-51-2.	Legislative intent.	33-51-6.	Incentives for preferred providers.
33-51-3.	Development of guidelines; promotion by Commissioner; authority of Commissioner.	33-51-7.	Health reimbursement arrangement only.
33-51-4.	Programs not considered unfair trade practice.		

Effective date. — This chapter became effective May 7, 2008.

Cross references. — Tax credit for qualified health insurance expenses, § 48-7-29.13.

Code Commission notes. — The repeal and reenactment of this chapter by Ga. L. 2008, p. 289, § 2, irreconcilably conflicted with and was treated as superseded by Ga. L. 2008, p. 292, § 3. See *County of Butts v. Strahan*, 151 Ga. 417 (1921).

Editor's notes. — Ga. L. 2008, p. 292, § 3, effective May 7, 2008, repealed the Code sections formerly codified at this chapter and enacted the current chapter. The former chapter consisted of Code Sections 33-51-1 through 33-51-4, relating to Georgia Basic Health Insurance Plan, and was based on Ga. L. 1991, p. 606, § 1; Ga. L. 1993, p. 1985, § 1.

33-51-1. Short title.

This chapter shall be known and may be cited as the “Georgia Affordable HSA Eligible High Deductible Health Plan.” (Code 1981, § 33-51-1, enacted by Ga. L. 2008, p. 292, § 3/HB 977.)

33-51-2. Legislative intent.

It is the intent of the General Assembly:

(1) To authorize the Commissioner to establish flexible guidelines for health savings account eligible high deductible plan designs which will be affordable to Georgians and to increase the availability of these types of plans by accident and sickness insurers licensed to transact such insurance in this state;

(2) To encourage the offering of affordable health savings account eligible high deductible plans, as required under the rules of the federal Internal Revenue Service related to the establishment of health savings accounts, with the specific intent of reaching many otherwise uninsured Georgians and the general intent of creating affordable comprehensive health insurance for all Georgians; and

(3) To enhance the affordability of insurance with the flexible health savings account eligible high deductible plans allowed under this chapter by allowing rewards and incentives for participation in and adherence to health behaviors that recognize the value of the personal responsibility of each citizen to maintain good health, seek preventative care services, and comply with approved treatments. (Code 1981, § 33-51-2, enacted by Ga. L. 2008, p. 292, § 3/HB 977.)

33-51-3. Development of guidelines; promotion by Commissioner; authority of Commissioner.

(a) The Commissioner shall develop flexible guidelines for coverage and approval of health savings account eligible high deductible plans

which are designed to qualify under federal and state requirements as high deductible health plans for use with health savings accounts which comply with federal requirements under the applicable provisions of the federal Internal Revenue Code for high deductible health plans sold in connection with health savings accounts.

(b) The Commissioner shall be authorized to encourage and promote the marketing of health savings account eligible high deductible plans by accident and sickness insurers in this state; provided, however, that nothing in this Code section shall be construed to authorize the sale of insurance in violation of Chapter 3 of this title or interstate sales of insurance.

(c) The Commissioner shall be authorized to conduct a national study of health savings account eligible high deductible plans available in other states and to determine if and how these products serve the uninsured and if they should be made available to Georgians.

(d) The Commissioner shall be authorized to develop an automatic or fast track approval process for health savings account eligible high deductible plans already approved under the laws and regulations of this state or other states.

(e) The Commissioner shall be authorized to promulgate such rules and regulations as he or she deems necessary and appropriate for the design, promotion, and regulation of health savings account eligible high deductible plans, including rules and regulations for the expedited review of standardized policies, advertisements and solicitations, and other matters deemed relevant by the Commissioner. (Code 1981, § 33-51-3, enacted by Ga. L. 2008, p. 292, § 3/HB 977.)

33-51-4. Programs not considered unfair trade practice.

Insurers that include and operate wellness and health promotion programs, disease and condition management programs, health risk appraisal programs, and similar provisions in their high deductible health policies in keeping with federal requirements shall not be considered to be engaging in unfair trade practices under Code Section 33-6-4 with respect to references to the practices of illegal inducements, unfair discrimination, and rebating. (Code 1981, § 33-51-4, enacted by Ga. L. 2008, p. 292, § 3/HB 977.)

33-51-5. Nonpreferred provider reimbursement.

There shall be no required relationship between preferred provider and nonpreferred provider plan reimbursements for health savings account eligible high deductible plans using nonpreferred provider reimbursements. Such plans, however, shall not:

(1) Unfairly deny health benefits for medically necessary covered services;

(2) Have differences in benefit levels payable to preferred providers compared to other providers that unfairly deny benefits for covered services;

(3) Have a plan coinsurance percentage applicable to benefit levels for services provided by nonpreferred providers that is less than 60 percent of the benefit levels under the policy for such services; or

(4) Have an adverse effect on the availability or the quality of services. (Code 1981, § 33-51-5, enacted by Ga. L. 2008, p. 292, § 3/HB 977.)

33-51-6. Incentives for preferred providers.

Notwithstanding the provisions of paragraphs (2) and (3) of Code Section 33-51-5, health benefit plans providing incentives for covered persons to use pharmaceutical or dental services of preferred providers shall provide, and clearly indicate, that the payment or reimbursement for a noncontracting provider of covered pharmaceutical or dental services shall be the same as the payment or reimbursement for a preferred provider of covered pharmaceutical or dental services; provided, however, that the health benefit plan shall not be required to make payment or reimbursement in an amount which is greater than the actual fee charged by the provider for such dental or pharmaceutical services. (Code 1981, § 33-51-6, enacted by Ga. L. 2008, p. 292, § 3/HB 977.)

33-51-7. Health reimbursement arrangement only.

(a) The Commissioner shall be authorized to allow health reimbursement arrangement only plans that encourage employer financial support of health insurance or health related expenses recognized under the rules of the federal Internal Revenue Service to be approved for sale in connection with or packaged with individual health insurance policies otherwise approved by the Commissioner.

(b) Health reimbursement arrangement only plans that are not sold in connection with or packaged with individual health insurance policies shall not be considered insurance under this title.

(c) Individual insurance policies offered or funded through health reimbursement arrangements shall not be considered employer sponsored or group coverage for purposes of this title, and nothing in this Code section shall be interpreted to require an insurer to offer an individual health insurance policy for sale in connection with or

packaged with a health reimbursement arrangement or to accept premiums from health reimbursement arrangement plans for individual health insurance policies. (Code 1981, § 33-51-7, enacted by Ga. L. 2009, p. 737, § 2/SB 94.)

Effective date. — This Code section became effective May 5, 2009.

CHAPTER 54

GENETIC TESTING

33-54-1. Legislative findings and determinations; intent of chapter.

Law reviews. — For article, “The Burden of Knowledge,” see 43 Ga. L. Rev. 297 (2009).

CHAPTER 56

RISK-BASED CAPITAL LEVELS

Sec.		risk-based capital level plan;
33-56-1.	Definitions.	hearing; out-of-state filing.
33-56-3.	Company action level events; preparation and submission of	

33-56-1. Definitions.

As used in this chapter, the term:

- (1) “Adjusted RBC report” means an RBC report which has been adjusted in accordance with subsection (e) of Code Section 33-56-2.
- (2) “Corrective order” means an order issued by the Commissioner specifying corrective actions which the Commissioner has determined are required.
- (3) “Domestic insurer” means an insurer as defined in paragraph (4) of Code Section 33-3-1.
- (4) “Foreign insurer” means any insurance company which is licensed to do business in this state under Chapter 3 of this title, but is not a domestic insurer.

(4.1) "Health organization" means any health maintenance organization; limited health service organization; hospital, medical, or dental indemnity or service corporation; or other managed care organization licensed under this title; provided, however, that health organization does not include any life and health insurer or property and casualty insurer.

(4.2) "Insurer" includes without limitation any health organization.

(5) "Life and health insurer" means any insurance company licensed to write insurance as defined in Code Section 33-7-2 or 33-7-4 or a licensed property and casualty insurer writing only accident and health insurance.

(6) "NAIC" means the National Association of Insurance Commissioners.

(7) "Negative trend" means, with respect to a life and health insurer, a negative trend over a period of time, as determined in accordance with the trend test calculation included in the life RBC instructions.

(8) "Property and casualty insurer" means any insurance company licensed to write insurance as defined in Code Section 33-7-3 or 33-7-6 but shall not include monoline mortgage guaranty insurers, financial guaranty insurers, and title insurers.

(9) "RBC" means risk-based capital.

(10) "RBC instructions" means the RBC report including risk-based capital instructions adopted by the NAIC, as such RBC instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

(11) "RBC level" means an insurer's company action level RBC, regulatory action level RBC, authorized control level RBC, or mandatory control level RBC where:

(A) "Authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions;

(B) "Company action level RBC" means, with respect to any insurer, the product of 2.0 and its authorized control level RBC;

(C) "Mandatory control level RBC" means the product of .70 and the authorized control level RBC; and

(D) "Regulatory action level RBC" means the product of 1.5 and its authorized control level RBC.

(12) "RBC plan" means a comprehensive financial plan containing the elements specified in subsection (b) of Code Section 33-56-3. If the Commissioner rejects the RBC plan and it is revised by the insurer, with or without the Commissioner's recommendation, the plan shall be called the revised RBC plan.

(13) "RBC report" means the report required in Code Section 33-56-2.

(14) "Total adjusted capital" means the sum of:

(A) An insurer's statutory capital and surplus, which in the case of a health organization shall be determined in accordance with the statutory accounting applicable to the annual financial statements required to be filed; and

(B) Such other items, if any, as the RBC instructions may provide. (Code 1981, § 33-56-1, enacted by Ga. L. 1996, p. 928, § 1; Ga. L. 2000, p. 1246, §§ 8, 9; Ga. L. 2011, p. 449, § 12/HB 413.)

The 2011 amendment, effective July 1, 2011, inserted "life" near the end of paragraph (7).

33-56-3. Company action level events; preparation and submission of risk-based capital level plan; hearing; out-of-state filing.

(a) As used in this Code section, "company action level event" means any of the following events:

(1) The filing of an RBC report by an insurer which indicates that:

(A) The insurer's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC;

(B) If a life and health insurer, the insurer has total adjusted capital which is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 2.5 and has a negative trend; or

(C) If a property and casualty insurer, the insurer has total adjusted capital which is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 3.0 and triggers the trend test determined in accordance with the trend test calculation included in the property and casualty RBC instructions;

(2) The notification by the Commissioner to the insurer of an adjusted RBC report that indicates an event in paragraph (1) of this

subsection, provided the insurer does not challenge the adjusted RBC report under Code Section 33-56-7; or

(3) If, pursuant to Code Section 33-56-7, an insurer challenges an adjusted RBC report that indicates the event in paragraph (1) of this subsection, the notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge.

(b) In the event of a company action level event, the insurer shall prepare and submit to the Commissioner an RBC plan which shall:

(1) Identify the conditions which contribute to the company action level event;

(2) Contain proposals of corrective actions which the insurer intends to take and would be expected to result in the elimination of the company action level event;

(3)(A) Provide projections of the insurer's financial results in the current year and at least the four succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital and surplus, or surplus, except as otherwise provided by subparagraph (B) of this paragraph.

(B) In the case of a health organization, provide projections of the health organization's financial results in the current year and at least the two succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory balance sheet, operating income, net income, capital and surplus, and RBC levels. The projections for both new and renewal business may include separate projections for each major line of business and separately identify each significant income, expense, and benefit component;

(4) Identify the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions; and

(5) Identify the quality of, and problems associated with, the insurer's business, including but not limited to its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance, if any, in each case.

(c) An RBC plan shall be submitted:

(1) Within 45 days of the company action level event; or

(2) If the insurer challenges an adjusted RBC report pursuant to Code Section 33-56-7, within 45 days after notification to the insurer

that the Commissioner has, after a hearing, rejected the insurer's challenge.

(d) Within 60 days after the submission by an insurer of an RBC plan to the Commissioner, the Commissioner shall notify the insurer whether the RBC plan shall be implemented or is, in the judgment of the Commissioner, unsatisfactory. If the Commissioner determines the RBC plan is unsatisfactory, the notification to the insurer shall set forth the reasons for the determination and may set forth proposed revisions which will render the RBC plan satisfactory in the judgment of the Commissioner. Upon notification from the Commissioner, the insurer shall prepare a revised RBC plan, which may incorporate by reference any revisions proposed by the Commissioner, and shall submit the revised RBC plan to the Commissioner:

(1) Within 45 days after the notification from the Commissioner; or

(2) If the insurer challenges the notification from the Commissioner under Code Section 33-56-7, within 45 days after a notification to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge.

(e) In the event of a notification by the Commissioner to an insurer that the insurer's RBC plan or revised RBC plan is unsatisfactory, the Commissioner may at the Commissioner's discretion, subject to the insurer's right to a hearing under Code Section 33-56-7, specify in the notification that the notification constitutes a regulatory action level event.

(f) Every domestic insurer which files an RBC plan or revised RBC plan with the Commissioner shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner in any state in which the insurer is authorized to do business if:

(1) Such state has an RBC provision substantially similar to subsection (a) of Code Section 33-56-8; and

(2) The insurance commissioner of that state has notified the insurer of its request for the filing in writing, in which case the insurer shall file a copy of the RBC plan or revised RBC plan in that state no later than the later of:

(A) Fifteen days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with the state; or

(B) The date on which the RBC plan or revised RBC plan is filed under subsection (c) or (d) of this Code section. (Code 1981, § 33-56-3, enacted by Ga. L. 1996, p. 928, § 1; Ga. L. 2000, p. 1246, § 11; Ga. L. 2011, p. 449, § 13/HB 413.)

The 2011 amendment, effective July 1, 2011, deleted “or” from the end of subparagraph (a)(1)(A); added “or” at the end of subparagraph (a)(1)(B); and added subparagraph (a)(1)(C).

CHAPTER 57

CONSUMERS' INSURANCE ADVOCATE

Sec. 33-57-5. Additional service and notice requirements for rate in- creases; depositions and discovery.

33-57-5. Additional service and notice requirements for rate increases; depositions and discovery.

(a) In addition to other requirements of service and notice imposed by law, a copy of any request for insurance or health benefit plan rate filing:

(1) Which alone or in combination with any previous rate filing would result in a rate increase of:

(A) Any amount, but no decrease shall be subject to such provisions; provided, however, that

(B) Rate information, including information submitted, requested for submission, or required to be submitted to the Commissioner or department for purposes of determining whether insurance rates are excessive, inadequate, or unfairly discriminatory, and any correspondence or paper filed with or issued by the department or by the Commissioner in connection with such rate information shall be served by copy upon the advocate, and the Office of Consumer Affairs shall require by rule or regulation that financial information of insurers, including a summary of products offered, basic rates applicable to such products, financial statements, officers' salaries, notifications of rate increases, and, as to health insurers, actuarial summaries and opinions relating to consumer choice options on managed care products shall be submitted to the department and the advocate on a quarterly basis; or

(2) Made within 36 months after any rate filing described by paragraph (1) of this subsection

shall also be served on the advocate, and the advocate shall be notified of any other correspondence or paper filed with or issued by the department or by the Commissioner in connection with such rate filing. A notice of such filing shall be sent to the advocate certified mail or

statutory overnight delivery, return receipt requested. The department or the Commissioner shall not proceed to hear or determine any petition, complaint, proceeding, or request for rate filing in which the advocate is entitled to appear unless it shall affirmatively appear that the advocate was given at least ten days' written notice thereof, unless such notice is affirmatively waived in writing or the advocate appears and specifically waives such notice. The advocate may also request copies of any application, complaint, pleading, notice, or other document filed with or issued by the department or by the Commissioner. Until such time as the General Assembly specifically appropriates funds in an appropriations Act for the consumers' insurance advocate and such funds are available for expenditure, the filings required by this subsection shall not be required and shall not be made.

(b) In any case of a rate filing which is subject to the provisions of subsection (a) of this Code section, the advocate is authorized to take depositions and obtain discovery of any matter which is not privileged and which is relevant to the subject matter involved in any proceeding or petition before the department or by the Commissioner in the same manner and subject to the same procedures which would otherwise be applicable if such proceeding was then pending before a superior court. Copies of materials and information obtained through such discovery shall be made available to the department. The superior courts and judges and clerks thereof are authorized to issue all orders, injunctions, and subpoenas and to take all actions necessary to carry out this subsection. (Code 1981, § 33-57-5, enacted by Ga. L. 1999, p. 335, § 2; Ga. L. 2000, p. 1589, § 3; Ga. L. 2012, p. 701, § 2/HB 786.)

The 2012 amendment, effective July 1, 2012, in subsection (a), inserted "that" at the end of subparagraph (a)(1)(A) and added the last sentence of the ending undesignated paragraph.

CHAPTER 59

LIFE SETTLEMENTS

Sec.	Sec.
33-59-2. Definitions.	33-59-4. Suspension, revocation, or refusal to renew licenses; grounds; hearing required.
33-59-3. License requirements; representation of producers; exceptions; application and renewal; fees; licenses for legal entities; investigation by Commissioner and issuance of license; nonresident applicants; required information from provider; continued training requirements.	33-59-5. Filing of contracts and disclosure statements with the Commissioner; approval or disapproval.
	33-59-6. Filing of annual statement with the Commissioner; confidential information.

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| <p>Sec.</p> <p>33-59-7. Examination of licensees and businesses; record retention requirements; examination reports; orders; hearings; confidentiality of examination information; conflict of interest; immunity; investigative authority of the Commissioner.</p> <p>33-59-8. Advertising.</p> <p>33-59-9. Required written disclosures; consequence for failure to provide.</p> <p>33-59-10. Lender-financed premiums using policy as collateral; disclosures and certifications.</p> <p>33-59-11. Required documents and information; confidentiality; seller's right to rescind; escrow proceedings; failure to tender consideration; limitation on contracts with the insured for the purpose of determining the insured's health status.</p> | <p>Sec.</p> <p>33-59-12. Promulgation of regulations; determining governing law when multiple owners.</p> <p>33-59-13. Unlawful activities deemed fraudulent life settlement act.</p> <p>33-59-14. Violations; required statement; reporting of fraudulent acts to the Commissioner; immunity for providing information concerning fraudulent acts; confidentiality of documents and evidence; mandatory adoption of antifraud initiatives by providers.</p> <p>33-59-15. Remedies and penalties for violations; procedural issues.</p> <p>33-59-16. Fraudulent life settlement acts prohibited; criminal and civil penalties; revocation of license.</p> <p>33-59-17. Unfair trade practice.</p> <p>33-59-18. Transacting business permitted while the provider's license application is pending.</p> |
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33-59-1. Short title.

Editor's notes. — Ga. L. 2009, p. 370, § 1, effective July 1, 2009, reenacted this

Code section without change. Refer to the bound volume for text of this Code section.

RESEARCH REFERENCES

ALR. — State regulation of viatical life insurance programs, viatical settlements, and viatical investments, 28 ALR6th 281.

33-59-2. Definitions.

As used in this chapter, the term:

(1) "Advertisement" means any written, electronic, or printed communication or any communication by means of recorded telephone messages or transmitted on radio, television, the Internet, or similar communications media, including film strips, motion pictures, and videos, published, disseminated, circulated, or placed directly before the public in this state for the purpose of creating an interest in or inducing a person to purchase or sell, assign, devise, bequest, or transfer the death benefit or ownership of a life insurance policy or an interest in a life insurance policy pursuant to a life settlement contract.

(2) "Business of life settlements" means an activity involved in, but not limited to, offering to enter into, soliciting, negotiating, procuring, effectuating, monitoring, or tracking of life settlement contracts.

(3) "Chronically ill" means:

(A) Being unable to perform at least two activities of daily living such as eating, toileting, transferring, bathing, dressing, or continence;

(B) Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment; or

(C) Having a level of disability similar to that described in subparagraph (A) of this paragraph as determined by the United States Secretary of Health and Human Services.

(4) "Financing entity" means an underwriter, placement agent, lender, purchaser of securities, purchaser of a policy or certificate from a provider, credit enhancer, or any entity that has a direct ownership in a policy or certificate that is the subject of a life settlement contract, but:

(A) Whose principal activity related to the transaction is providing funds to effect the life settlement contract or purchase of one or more policies; and

(B) Who has an agreement in writing with one or more providers to finance the acquisition of life settlement contracts.

"Financing entity" does not include a nonaccredited investor or purchaser.

(5) "Financing transaction" means a transaction in which a licensed provider obtains financing from a financing entity including, without limitation, any secured or unsecured financing, any securitization transaction, or any securities offering which either is registered or exempt from registration under federal and state securities law.

(6) "Fraudulent life settlement act" includes:

(A) Acts or omissions committed by any person who, knowingly and with intent to defraud, for the purpose of depriving another of property or for pecuniary gain, engages in acts, or permits its employees or its agents to engage in acts, including, but not limited to:

(i) Presenting, causing to be presented, or preparing with knowledge and belief that it will be presented to or by a provider, premium finance lender, life settlement broker, insurer, insur-

ance producer, or any other person, false material information, or concealing material information, as part of, in support of, or concerning a fact material to one or more of the following:

(I) An application for the issuance of a life settlement contract or insurance policy;

(II) The underwriting of a life settlement contract or insurance policy;

(III) A claim for payment or benefit pursuant to a life settlement contract or insurance policy;

(IV) Premiums paid on an insurance policy;

(V) Payments and changes in ownership or beneficiary made in accordance with the terms of a life settlement contract or insurance policy;

(VI) The reinstatement or conversion of an insurance policy;

(VII) The solicitation, offer to enter into, or effectuation of a life settlement contract or insurance policy;

(VIII) The issuance of written evidence of life settlement contracts or insurance;

(IX) Any application for or the existence of or any payments related to a loan secured directly or indirectly by an interest in a life insurance policy; or

(X) Stranger originated life insurance as defined in paragraph (24) of this Code section;

(ii) Failing to disclose to the insurer where the request for such disclosure has been asked for by the insurer that the prospective insured has undergone a life expectancy evaluation by any person or entity other than the insurer or its authorized representatives in connection with the issuance of the policy;

(iii) Employing any device, scheme, or artifice to defraud in the business of life settlements; or

(iv) In the solicitation, application, or issuance of a life insurance policy, employing any device, scheme, or artifice in violation of state insurable interest laws; and

(B) In the furtherance of a fraud or to prevent the detection of a fraud, acts or omissions of any person, its employees, or its agents acting with such person's permission, to:

(i) Remove, conceal, alter, destroy, or sequester from the Commissioner the assets or records of a licensee or other person engaged in the business of life settlements;

(ii) Misrepresent or conceal the financial condition of a licensee, financing entity, insurer, or other person;

(iii) Transact the business of life settlements in violation of laws requiring a license, certificate of authority, or other legal authority for the transaction of the business of life settlements;

(iv) File with the Commissioner or the chief insurance regulatory official of another jurisdiction a document containing false information or otherwise conceal information about a material fact from the Commissioner;

(v) Engage in embezzlement, theft, misappropriation, or conversion of moneys, funds, premiums, credits, or other property of a provider, insurer, insured, insurance policy owner, or any other person engaged in the business of life settlements or insurance;

(vi) Knowingly and with intent to defraud, enter into, broker, or otherwise deal in a life settlement contract, the subject of which is a life insurance policy that was obtained by presenting false information concerning any fact material to the policy or by concealing, for the purpose of misleading another, information concerning any fact material to the policy, where the owner or the owner's agent intended to defraud the policy's issuer;

(vii) Attempt to commit, assist, aid, or abet in the commission of, or conspiracy to commit, the acts or omissions specified in this paragraph; or

(viii) Misrepresent the state of residence of an owner to be a state or jurisdiction that does not have a law substantially similar to this chapter for the purpose of evading or avoiding the provisions of this chapter.

(7) "Insured" means the person covered under the policy being considered for sale in a life settlement contract.

(8) "Life expectancy" means the arithmetic mean of the number of months the insured under the life insurance policy to be settled can be expected to live as determined by professionally competent individuals considering medical records and appropriate experiential data.

(9) "Life insurance producer" means any person licensed in this state as a resident or nonresident insurance producer who has received qualification or authority for life insurance coverage or a life line of coverage pursuant to Chapter 23 of this title.

(10) "Life settlement broker" means a person who, on behalf of an owner and for a fee, commission, or other valuable consideration, offers or attempts to negotiate life settlement contracts between an

owner and providers. A life settlement broker represents only the owner and owes a fiduciary duty to the owner to act according to the owner's instructions, and in the best interest of the owner, notwithstanding the manner in which the life settlement broker is compensated. A life settlement broker does not include an attorney, certified public accountant, or financial planner retained in the type of practice customarily performed in their professional capacity to represent the owner whose compensation is not paid directly or indirectly by the provider or any other person, except the owner.

(11)(A) "Life settlement contract" means a written agreement entered into between a provider and an owner establishing the terms under which compensation or any thing of value will be paid, which compensation or thing of value is less than the expected death benefit of the insurance policy or certificate, in return for the owner's assignment, transfer, sale, devise, or bequest of the death benefit or any portion of an insurance policy or certificate of insurance for compensation; provided, however, that the minimum value for a life settlement contract shall be greater than a cash surrender value or accelerated death benefit available at the time of an application for a life settlement contract. "Life settlement contract" also includes the transfer for compensation or value of ownership or beneficial interest in a trust or other entity that owns such policy if the trust or other entity was formed or availed of for the principal purpose of acquiring one or more life insurance contracts, which life insurance contract insures the life of a person residing in this state.

(B) "Life settlement contract" also includes:

(i) A written agreement for a loan or other lending transaction, secured primarily by an individual or group life insurance policy; and

(ii) A premium finance loan made for a policy on or before the date of issuance of the policy where:

(I) The loan proceeds are not used solely to pay premiums for the policy and any costs or expenses incurred by the lender or the borrower in connection with the financing;

(II) The owner receives on the date of the premium finance loan a guarantee of the future life settlement value of the policy; or

(III) The owner agrees on the date of the premium finance loan to sell the policy or any portion of its death benefit on any date following the issuance of the policy.

(C) Life settlement contract does not include:

(i) A policy loan by a life insurance company pursuant to the terms of the life insurance policy or accelerated death provisions contained in the life insurance policy, whether issued with the original policy or as a rider;

(ii) A premium finance loan, as defined in paragraph (18) of this Code section, or any loan made by a bank or other licensed financial institution, provided that neither default on such loan nor the transfer of the policy in connection with such default is pursuant to an agreement or understanding with any other person for the purpose of evading regulation under this chapter;

(iii) A collateral assignment of a life insurance policy by an owner;

(iv) A loan made by a lender that does not violate Chapter 22 of this title, provided such loan is not described in this paragraph as being included in the definition of a life settlement contract and is not otherwise within the definition of life settlement contract;

(v) An agreement where all the parties are closely related to the insured by blood or law or have a lawful substantial economic interest in the continued life, health, and bodily safety of the person insured or are trusts established primarily for the benefit of such parties;

(vi) Any designation, consent, or agreement by an insured who is an employee of an employer in connection with the purchase by the employer, or trust established by the employer, of life insurance on the life of the employee;

(vii) A bona fide business succession planning arrangement between:

(I) One or more shareholders in a corporation or between a corporation and one or more of its shareholders or one or more trust established by its shareholders;

(II) One or more partners in a partnership or between a partnership and one or more of its partners or one or more trust established by its partners; or

(III) One or more members in a limited liability company or between a limited liability company and one or more of its members or one or more trust established by its members;

(viii) An agreement entered into by a service recipient, or a trust established by the service recipient, and a service provider or a trust established by the service provider, who performs

significant services for the service recipient's trade or business;
or

(ix) Any other contract, transaction, or arrangement from the definition of life settlement contract that the Commissioner determines is not of the type intended to be regulated by this chapter.

(12) "Net death benefit" means the amount of the life insurance policy or certificate to be settled less any outstanding debts or liens.

(13) "Owner" means the owner of a life insurance policy or a certificate holder under a group policy, with or without a terminal illness, who enters or seeks to enter into a life settlement contract. For the purposes of this chapter, an owner shall not be limited to an owner of a life insurance policy or a certificate holder under a group policy that insures the life of an individual with a terminal or chronic illness or condition except where specifically addressed. "Owner" does not include:

(A) Any provider or other licensee under this chapter;

(B) A qualified institutional buyer as defined in Rule 144A of the federal Securities Act of 1933, as amended;

(C) A financing entity;

(D) A special purpose entity; or

(E) A related provider trust.

(14) "Patient identifying information" means an insured's address, telephone number, facsimile number, e-mail address, photograph or likeness, employer, employment status, social security number, or any other information that is likely to lead to the identification of the insured.

(15) "Person" means any natural person or a legal entity, including, but not limited to, a partnership, limited liability company, association, trust, or corporation.

(16) "Policy" means an individual or group policy, group certificate, contract, or arrangement of life insurance owned by a resident of this state, regardless of whether delivered or issued for delivery in this state.

(17) "Premium finance loan" is a loan made primarily for the purposes of making premium payments on a life insurance policy, which loan is secured by an interest in such life insurance policy.

(18) "Provider" means a person, other than an owner, who enters into or effectuates a life settlement contract with an owner. A provider does not include:

(A) Any bank, savings bank, savings and loan association, or credit union;

(B) A licensed lending institution or creditor or secured party pursuant to a premium finance loan agreement which takes an assignment of a life insurance policy or certificate issued pursuant to a group life insurance policy as collateral for a loan;

(C) The insurer of a life insurance policy or rider to the extent of providing accelerated death benefits or riders under this title or cash surrender value;

(D) Any natural person who enters into or effectuates no more than one agreement in a calendar year for the transfer of a life insurance policy or certificate issued pursuant to a group life insurance policy for compensation or any thing of value less than the expected death benefit payable under the policy;

(E) A purchaser;

(F) Any authorized or eligible insurer that provides stop-loss coverage to a provider, purchaser, financing entity, special purpose entity, or related provider trust;

(G) A financing entity;

(H) A special purpose entity;

(I) A related provider trust;

(J) A life settlement broker; or

(K) An accredited investor or qualified institutional buyer as defined in, respectively, Regulation D, Rule 501, or Rule 144A of the federal Securities Act of 1933, as amended, who purchases a life settlement policy from a provider.

(19) "Purchased policy" means a policy or group certificate that has been acquired by a provider pursuant to a life settlement contract.

(20) "Purchaser" means a person who pays compensation or any thing of value as consideration for a beneficial interest in a trust which is vested with, or for the assignment, transfer, or sale of, an ownership or other interest in a life insurance policy or a certificate issued pursuant to a group life insurance policy which has been the subject of a life settlement contract.

(21) "Related provider trust" means a titling trust or other trust established by a licensed provider or a financing entity for the sole purpose of holding the ownership or beneficial interest in purchased policies in connection with a financing transaction. In order to qualify as a related provider trust, the trust must have a written agreement

with the licensed provider under which the licensed provider is responsible for ensuring compliance with all statutory and regulatory requirements and under which the trust agrees to make all records and files relating to life settlement transactions available to the department as if those records and files were maintained directly by the licensed provider.

(22) “Settled policy” means a life insurance policy or certificate that has been acquired by a provider pursuant to a life settlement contract.

(23) “Special purpose entity” means a corporation, partnership, trust, limited liability company, or other legal entity formed solely to provide either directly or indirectly access to institutional capital markets for a financing entity or provider; or in connection with a transaction in which the securities in the special purpose entity are acquired by the owner or by a qualified institutional buyer as defined in Rule 144 promulgated under the federal Securities Act of 1933, as amended, or the securities pay a fixed rate of return commensurate with established asset-backed institutional capital markets.

(24) “Stranger originated life insurance” is a series of acts or a practice to initiate a life insurance policy for the benefit of a third-party investor who, at the time of policy origination, has no insurable interest in the insured. Stranger originated life insurance acts or practices include, but are not limited to, cases in which life insurance is purchased with resources or guarantees from or through a person or entity who, at the time of policy inception, could not lawfully initiate the policy himself or herself or itself, and where, at the time of inception, there is an arrangement or agreement to directly or indirectly transfer the ownership of the policy or the policy benefits to a third party. Trusts that are created to give the appearance of insurable interest and are used to initiate policies for investors violate insurable interest laws and the prohibition against wagering on life. Stranger originated life insurance arrangements do not include those practices set forth in subparagraph (C) of paragraph (11) of this Code section.

(25) “Terminally ill” means having an illness or sickness that can reasonably be expected to result in death in 24 months or less. (Code 1981, § 33-59-2, enacted by Ga. L. 2005, p. 998, § 1/SB 217; Ga. L. 2009, p. 370, § 1/SB 61; Ga. L. 2010, p. 878, § 33/HB 1387.)

The 2009 amendment, effective April 30, 2009, for purposes of promulgating rules and regulations by the Commissioner of Insurance and for all other purposes effective July 1, 2009, rewrote this Code section.

The 2010 amendment, effective June 3, 2010, part of an Act to revise, modernize, and correct the Code, substituted “Provider” for “Provide” at the beginning of the introductory language of paragraph (18).

33-59-3. License requirements; representation of producers; exceptions; application and renewal; fees; licenses for legal entities; investigation by Commissioner and issuance of license; nonresident applicants; required information from provider; continued training requirements.

(a) No person, wherever located, shall act as a provider or life settlement broker with an owner or multiple owners who are residents of this state without first having obtained a license or acknowledgment of registration from the Commissioner. If there is more than one owner on a single policy and the owners are residents of different states, the life settlement contract shall be governed by the law of the state in which the owner having the largest percentage ownership resides or, if the owners hold equal ownership, the state of residence of one owner agreed upon in writing by all owners.

(b) Application for a provider license or life settlement broker registration shall be made to the Commissioner by the applicant on a form prescribed by the Commissioner and the application shall be accompanied by a fee in an amount established by the Commissioner; provided, however, that the license and renewal fees for a provider license shall be reasonable and that the registration and renewal fees for a life settlement broker registration shall not exceed those established for an insurance producer, as such fees are otherwise provided for in this title.

(c) A life insurance producer who has been duly licensed as a resident insurance producer with a life line of authority in this state or his or her home state for at least one year and is licensed as a nonresident producer in this state shall be deemed to meet the licensing and registration requirements of this Code section and shall be permitted to operate as a life settlement broker.

(d) Not later than 30 days from the first day of operating as a life settlement broker, the life insurance producer shall notify the Commissioner that he or she is acting as a life settlement broker on a form prescribed by the Commissioner and shall pay any applicable fee to be determined by the Commissioner. Notification shall include an acknowledgment by the life insurance producer that he or she will operate as a life settlement broker in accordance with this chapter.

(e) The insurer that issued the policy that is the subject of a life settlement contract shall not be responsible for any act or omission of a life settlement broker, provider, or purchaser arising out of or in connection with the life settlement transaction unless the insurer receives compensation for the placement of a life settlement contract from the provider, purchaser, or life settlement broker in connection with the life settlement contract.

(f) A person licensed as an attorney, certified public accountant, or financial planner accredited by a nationally recognized accreditation agency who is retained to represent the owner and whose compensation is not paid directly or indirectly by the provider or purchaser may negotiate life settlement contracts on behalf of the owner without having to obtain a license as a life settlement broker.

(g) Licenses may be renewed every year on May 1 upon payment of the periodic renewal fee. Failure to pay the fee within the terms prescribed shall result in the automatic revocation of the license requiring periodic renewal.

(h) The term of a provider license shall be equal to that of a domestic stock life insurance company and the term of a life settlement broker registration shall be equal to that of an insurance producer license. Licenses or registrations requiring periodic renewal may be renewed on their anniversary date upon payment of the periodic renewal fee as specified in subsection (b) of this Code section. Failure to pay the fees on or before the renewal date shall result in expiration of the license or registration.

(i) The applicant shall provide such information as the Commissioner may require on forms prepared by the Commissioner. The Commissioner shall have the authority, at any time, to require such applicant to fully disclose the identity of its stockholders, except stockholders owning fewer than 10 percent of the shares of an applicant whose shares are publicly traded, partners, officers, and employees, and the Commissioner may, in the exercise of the Commissioner's sole discretion, refuse to issue such a license in the name of any person if not satisfied that any officer, employee, stockholder, or partner thereof who may materially influence the applicant's conduct meets the standards of this chapter.

(j) A license issued to a partnership, corporation, or other entity authorizes all members, officers, and designated employees to act as a licensee under the license if those persons are named in the application and any supplements to the application.

(k) Upon the filing of an application and the payment of the license fee, the Commissioner shall make an investigation of each applicant and may issue a license if the Commissioner finds that the applicant:

- (1) If a provider, has provided a detailed plan of operation;
- (2) Is competent and trustworthy and intends to transact its business in good faith;
- (3) Has a good business reputation and has had experience, training, or education so as to be qualified in the business for which the license is applied;

(4) If the applicant is a legal entity, is formed or organized pursuant to the laws of this state or is a foreign legal entity authorized to transact business in this state or provides a certificate of good standing from the state of its domicile; and

(5) Has provided to the Commissioner an antifraud plan that meets the requirements of Code Section 33-59-14 and includes:

(A) A description of the procedures for detecting and investigating possible fraudulent acts and procedures for resolving material inconsistencies between medical records and insurance applications;

(B) A description of the procedures for reporting fraudulent insurance acts to the Commissioner;

(C) A description of the plan for antifraud education and training of its underwriters and other personnel; and

(D) A written description or chart outlining the arrangement of the antifraud personnel who are responsible for the investigation and reporting of possible fraudulent insurance acts and investigating unresolved material inconsistencies between medical records and insurance applications.

(l) The Commissioner shall not issue any license to any nonresident applicant unless a written designation of an agent for service of process is filed and maintained with the Commissioner or unless the applicant has filed with the Commissioner the applicant's written irrevocable consent that any action against the applicant may be commenced against the applicant by service of process on the Commissioner.

(m) The Commissioner shall not issue a license to any applicant unless the applicant has an adequate net worth as prescribed by order, rule, or regulation.

(n) Each licensee shall file with the Commissioner on or before the first day of May of each year an annual statement containing such information as the Commissioner by rule may prescribe.

(o) A provider shall not use any person to perform the functions of a life settlement broker as defined in paragraph (10) of Code Section 33-59-2 unless the person holds a current, valid registration as a life settlement broker and as provided in this Code section.

(p) A life settlement broker shall not use any person to perform the functions of a provider as defined in paragraph (18) of Code Section 33-59-2 unless such person holds a current, valid license as a provider and as provided in this Code section.

(q) A provider and a life settlement broker shall provide to the Commissioner new or revised information about officers, 10 percent or

more stockholders, partners, directors, members, and designated employees within 30 days of any change.

(r) An individual registered as a life settlement broker shall complete on a biennial basis 15 hours of training related to life settlements and life settlement transactions as required by the Commissioner; provided, however, that a life insurance producer who is operating as a life settlement broker pursuant to this Code section shall not be subject to the requirements of this subsection. Any person failing to meet the requirements of this subsection shall be subject to the penalties imposed by the Commissioner. (Code 1981, § 33-59-3, enacted by Ga. L. 2005, p. 998, § 1/SB 217; Ga. L. 2009, p. 370, § 1/SB 61.)

The 2009 amendment, effective April 30, 2009, for purposes of promulgating rules and regulations by the Commis-

sioner of Insurance and for all other purposes effective July 1, 2009, rewrote this Code section.

33-59-4. Suspension, revocation, or refusal to renew licenses; grounds; hearing required.

(a) The Commissioner may suspend, revoke, or refuse to renew the license of any licensee if the Commissioner finds that:

(1) There was any material misrepresentation in the application for the license;

(2) The licensee or any officer, partner, member, or director has been guilty of fraudulent or dishonest practices, is subject to a final administrative action, or is otherwise shown to be untrustworthy or incompetent to act as a licensee;

(3) The provider demonstrates a pattern of unreasonably withholding payments to policy owners;

(4) The licensee no longer meets the requirements for initial licensure;

(5) The licensee or any officer, partner, member, or director has been convicted of a felony or any misdemeanor of which criminal fraud is an element; or the licensee has pleaded guilty or nolo contendere to any felony or any misdemeanor of which criminal fraud or moral turpitude is an element regardless of whether a judgment of conviction has been entered by the court;

(6) The provider has entered into any life settlement contract using a form that has not been approved pursuant to this chapter;

(7) The provider has failed to honor contractual obligations set out in a life settlement contract;

(8) The provider has assigned, transferred, or pledged a settled policy to a person other than a provider licensed in this state,

purchaser, accredited investor or qualified institutional buyer as defined, respectively, in Regulation D, Rule 501, or Rule 144A of the federal Securities Act of 1933, as amended, financing entity, special purpose entity, or related provider trust;

(9) The licensee or any officer, partner, member, or key management personnel has violated any of the provisions of this chapter; or

(10) The provider has failed to maintain an adequate net worth.

(b) Before the Commissioner denies a license application or suspends, revokes, or refuses to renew the license of any licensee under this chapter, the Commissioner shall conduct a hearing in accordance with Chapter 2 of this title. (Code 1981, § 33-59-4, enacted by Ga. L. 2005, p. 998, § 1/SB 217; Ga. L. 2009, p. 370, § 1/SB 61.)

The 2009 amendment, effective April 30, 2009, for purposes of promulgating rules and regulations by the Commissioner of Insurance and for all other purposes effective July 1, 2009, rewrote subsections (a) and (b), added paragraphs (a)(4) and (a)(10), deleted paragraph (a)(7), which read: "The licensee no longer meets the requirements for initial licensure;"; and deleted subsection (c),

which read: "If the Commissioner denies a license application or suspends, revokes, or refuses to renew the license of a life settlement provider or suspends, revokes, or refuses to renew a license of a life insurance producer pursuant to this chapter, the Commissioner shall conduct a hearing in accordance with Chapter 13 of Title 50."

33-59-5. Filing of contracts and disclosure statements with the Commissioner; approval or disapproval.

(a) No person may use any form of life settlement contract in this state unless it has been filed with and approved, if required, by the Commissioner in a manner that conforms with the filing procedures and any time restrictions or deeming provisions, if any, for life insurance forms, policies, and contracts.

(b) No insurer may, as a condition of responding to a request for verification of coverage or in connection with the transfer of a policy pursuant to a life settlement contract, require that the owner, insured, provider, or life settlement broker sign any form, disclosure, consent, waiver, or acknowledgment that has not been expressly approved by the Commissioner for use in connection with life settlement contracts in this state.

(c) A person shall not use a life settlement contract form or provide to an owner a disclosure statement form in this state unless first filed with and approved by the Commissioner. The Commissioner shall disapprove a life settlement contract form or disclosure statement form if, in the Commissioner's opinion, the contract or provisions contained therein fail to meet the requirements of Code Sections 33-59-8, 33-59-9, 33-59-11, and 33-59-15 or are unreasonable, contrary to the interests of

the public, or otherwise misleading or unfair to the owner. At the Commissioner's discretion, the Commissioner may require the submission of advertising material. (Code 1981, § 33-59-5, enacted by Ga. L. 2005, p. 998, § 1/SB 217; Ga. L. 2009, p. 370, § 1/SB 61.)

The 2009 amendment, effective April 30, 2009, for purposes of promulgating rules and regulations by the Commissioner of Insurance and for all other purposes effective July 1, 2009, designated the existing provisions as subsections (a) and (c); substituted the present provisions of subsection (a) for "A person may not use a life settlement contract or provide to a seller a disclosure statement form in this state unless filed with and approved by the Commissioner."; added subsection (b); and substituted the present provisions of

subsection (c) for "Any life settlement contract form or disclosure form filed with the Commissioner shall be deemed approved if it has not been disapproved within 60 days of the filing. The Commissioner shall disapprove a life settlement contract form or disclosure statement form if, in the Commissioner's opinion, the contract or provisions contained in it are unreasonable, contrary to the interests of the public, or otherwise misleading or unfair to the seller."

33-59-6. Filing of annual statement with the Commissioner; confidential information.

(a)(1) Each provider shall file with the Commissioner on or before May 1 of each year an annual statement containing such information as the Commissioner may prescribe by rule or regulation in addition to any other requirements for any policy settled within five years of policy issuance. In addition to any other requirements, the annual statement shall specify the total number, aggregate face amount, and life settlement proceeds of policies settled during the immediately preceding calendar year, together with a breakdown of the information by policy issue year. The annual statement shall also include the names of the insurance companies whose policies have been settled and the life settlement brokers that have settled said policies.

(2) Such information shall be limited to only those transactions where the insured is a resident of this state and shall not include individual transaction data regarding the business of life settlements or information that there is a reasonable basis to believe could be used to identify the owner or the insured.

(3) Every provider that willfully fails to file an annual statement as required in this Code section or willfully fails to reply within 30 days to a written inquiry by the Commissioner in connection therewith, shall, in addition to other penalties provided by this chapter, be subject, upon due notice and opportunity to be heard, to a penalty of up to \$250.00 per day of delay, not to exceed \$25,000.00 in the aggregate, for each such failure.

(b) Except as otherwise allowed or required by law, a provider, life settlement broker, insurance company, insurance producer, information

bureau, rating agency or company, or any other person with actual knowledge of an insured's identity shall not disclose the identity of an insured or information that there is a reasonable basis to believe could be used to identify the insured or the insured's financial or medical information to any other person unless the disclosure:

(1) Is necessary to effect a life settlement contract between the owner and a provider and the owner and insured have provided prior written consent to the disclosure;

(2) Is necessary to effectuate the sale of life settlement contracts, or interests therein, as investments, provided that the sale is conducted in accordance with applicable state and federal securities law and provided further that the owner and the insured have both provided prior written consent to the disclosure;

(3) Is provided in response to an investigation or examination by the Commissioner or any other governmental officer or agency or pursuant to the requirements of Code Section 33-59-7;

(4) Is a term or condition to the transfer of a policy by one provider to another provider, in which case the receiving provider shall be required to comply with the confidentiality requirements of this subsection;

(5) Is necessary to allow the provider or life settlement broker or its authorized representatives to make contacts for the purpose of determining health status. For the purposes of this paragraph, the term "authorized representative" shall not include any person who has or may have any financial interest in the settlement contract other than a provider, registered life settlement broker, financing entity, related provider trust, or special purpose entity. A provider or life settlement broker shall require its authorized representative to agree in writing to adhere to the privacy provisions of this chapter; or

(6) Is required to purchase stop-loss coverage.

(c) Nonpublic personal information solicited or obtained in connection with a proposed or actual life settlement contract shall be subject to the provisions applicable to financial institutions under the federal Gramm-Leach-Bliley Act, P.L. 106-102 (1999), and all other state and federal laws relating to confidentiality of nonpublic personal information. (Code 1981, § 33-59-6, enacted by Ga. L. 2005, p. 998, § 1/SB 217; Ga. L. 2009, p. 370, § 1/SB 61.)

The 2009 amendment, effective April 30, 2009, for purposes of promulgating rules and regulations by the Commissioner of Insurance and for all other pur-

poses effective July 1, 2009, rewrote subsections (a) and (b) and added subsection (c).

33-59-7. Examination of licensees and businesses; record retention requirements; examination reports; orders; hearings; confidentiality of examination information; conflict of interest; immunity; investigative authority of the Commissioner.

(a) The Commissioner may, when the Commissioner deems it reasonably necessary to protect the interests of the public, examine the business and affairs of any licensee or applicant for a license. The Commissioner may order any licensee or applicant to produce any records, books, files, or other information reasonably necessary to ascertain whether such licensee or applicant is acting or has acted in violation of the law or otherwise contrary to the interests of the public. The expenses incurred in conducting any examination shall be paid by the licensee or applicant.

(b) In lieu of an examination under this chapter of any foreign or alien licensee licensed in this state, the Commissioner may, at the Commissioner's discretion, accept an examination report on the licensee as prepared by the Commissioner for the licensee's state of domicile or port-of-entry state.

(c) Names of and individual identification data for all owners and insureds shall be considered private and confidential information and shall not be disclosed by the Commissioner unless required by law.

(d) Records of all consummated transactions and life settlement contracts shall be maintained by the provider for three years after the death of the insured and shall be available to the Commissioner for inspection during reasonable business hours.

(e)(1) Upon determining that an examination should be conducted, the Commissioner shall issue an examination warrant appointing one or more examiners to perform the examination and instructing them as to the scope of the examination. In conducting the examination, the examiner shall use methods common to the examination of any life settlement licensee and should use those guidelines and procedures set forth in an examiners' handbook adopted by a national organization. The Commissioner may also employ such other guidelines as the Commissioner may deem appropriate.

(2) Every licensee or person from whom information is sought, its officers, directors, and agents shall provide to the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents, assets, and computer or other recordings relating to the property, assets, business, and affairs of the licensee being examined. The officers, directors, employees, and agents of the licensee or person shall facilitate the examination and

aid in the examination so far as it is in their power to do so. The refusal of a licensee, by its officers, directors, employees, or agents, to submit to examination or to comply with any reasonable written request of the Commissioner shall be grounds for suspension or refusal of or nonrenewal of any license or authority held by the licensee to engage in the life settlement business or other business subject to the Commissioner's jurisdiction. Any proceedings for suspension, revocation, or refusal of any license or authority shall be conducted pursuant to Chapter 2 of this title.

(3) The Commissioner shall have the power to issue subpoenas, to administer oaths, and to examine under oath any person as to any matter pertinent to the examination. Upon the failure or refusal of a person to obey a subpoena, the Commissioner may petition a court of competent jurisdiction and, upon proper showing, the court may enter an order compelling the witness to appear and testify or produce documentary evidence.

(4) When making an examination under this Code section, the Commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals and specialists as examiners, the reasonable cost of which shall be borne by the licensee that is the subject of the examination.

(5) Nothing contained in this Code section shall be construed to limit the Commissioner's authority to terminate or suspend an examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this state. Findings of fact and conclusions made pursuant to any examination shall be prima-facie evidence in any legal or regulatory action.

(6) Nothing contained in this Code section shall be construed to limit the Commissioner's authority to use and, if appropriate, to make public any final or preliminary examination report, any examiner or licensee work papers or other documents, or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action which the Commissioner may, in his or her sole discretion, deem appropriate.

(f)(1) Examination reports shall be composed of (A) only facts appearing upon the books, records, or other documents of the licensee, its agents, or other persons examined or as ascertained from the testimony of the licensee's officers or agents or other persons examined concerning the licensee's affairs and (B) such conclusions and recommendations as the examiners find reasonably warranted from the facts.

(2) No later than 60 days following completion of the examination, the examiner in charge shall file with the Commissioner a verified

written report of examination under oath. Upon receipt of the verified report, the Commissioner shall transmit the report to the licensee examined, together with a notice that shall afford the licensee examined a reasonable opportunity of not more than 30 days to make a written submission or rebuttal with respect to any matters contained in the examination report and which shall become part of the report or to request a hearing on any matter in dispute if the Commissioner deems such written submission or rebuttal comments appropriate and consistent with the findings of the examination.

(3) In the event the Commissioner determines that regulatory action is appropriate as a result of an examination, the Commissioner may initiate any proceedings or actions provided by law.

(g)(1) Names and individual identification data for all owners, purchasers, and insureds shall be considered private and confidential information and shall not be disclosed by the Commissioner unless the disclosure is to another regulator or is required by law.

(2) Except as otherwise provided in this chapter, all examination reports, working papers, recorded information, documents, and copies thereof produced by, obtained by, or disclosed to the Commissioner or any other person in the course of an examination made under this chapter or in the course of analysis or investigation by the Commissioner of the financial condition or market conduct of a licensee shall be confidential by law and privileged, shall not be subject to the provisions of Article 4 of Chapter 18 of Title 50, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. The Commissioner is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as part of the Commissioner's official duties. The licensee being examined may have access to all documents used to make the report except documents and work papers that the Commissioner has deemed privileged.

(h)(1) An examiner shall not be appointed by the Commissioner if the examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under this chapter. This subsection shall not be construed to preclude automatically an examiner from being:

(A) An owner;

(B) An insured in a life settlement contract or insurance policy;
or

(C) A beneficiary in an insurance policy that is proposed for a life settlement contract.

(2) Notwithstanding the requirements of this subsection, the Commissioner may retain from time to time, on an individual basis, qualified actuaries, certified public accountants, or other similar individuals who are independently practicing their professions even though these persons may from time to time be similarly employed or retained by persons subject to examination under this chapter.

(i)(1) No cause of action shall arise nor shall any liability be imposed against the Commissioner, the Commissioner's authorized representatives, or any examiner appointed by the Commissioner for any statements made or conduct performed in good faith while carrying out the provisions of this chapter.

(2) No cause of action shall arise nor shall any liability be imposed against any person for the act of communicating or delivering information or data to the Commissioner or the Commissioner's authorized representative or examiner pursuant to an examination made under this chapter if the act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive. This paragraph shall not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person identified in paragraph (1) of this subsection.

(3) A person identified in paragraph (1) or (2) of this subsection shall be entitled to an award of attorney's fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander, or any other relevant tort arising out of activities in carrying out the provisions of this chapter and the party bringing the action was not substantially justified in doing so. For purposes of this subsection, a proceeding is substantially justified if it had a reasonable basis in law or fact at the time that it was initiated.

(j) The Commissioner may investigate suspected fraudulent life settlement acts and persons engaged in the business of life settlements. (Code 1981, § 33-59-7, enacted by Ga. L. 2005, p. 998, § 1/SB 217; Ga. L. 2009, p. 370, § 1/SB 61.)

The 2009 amendment, effective April 30, 2009, for purposes of promulgating rules and regulations by the Commissioner of Insurance and for all other purposes effective July 1, 2009, rewrote subsection (a); redesignated former paragraph (a)(3) as present subsection (b); in subsection (b), substituted "Commissioner" for "commissioner" near the end; added subsection (c); redesignated former subsections (b) through (f) as present subsections (d) through (h), respectively; rewrote subsections (d) through (g); in subsection (h), deleted the subsection

catchline "Conflict of interest."; in paragraph (h)(1), substituted "shall" for "may" in the first sentence and, in the second sentence, substituted "subsection" for "Code section" and substituted "preclude automatically" for "automatically preclude"; in subparagraph (h)(1)(A), substituted "An owner" for "A seller"; in subparagraph (h)(1)(B), substituted "life settlement contract or insurance" for "purchased"; in subparagraph (h)(1)(C), substituted "for" for "to be the subject of"; deleted former subsection (g), which read: "Cost of examinations. The expenses in-

curred in conducting any examination shall be paid by the licensee or applicant.”; redesignated former subsections (h) and (i) as present subsections (i) and (j), respectively; in subsection (i), deleted “Immunity from liability.” in the subsection catchline; in the last sentence of paragraph (i)(2), substituted “shall” for “does”

at the beginning; in the last sentence of paragraph (i)(3), substituted “subsection” for “paragraph” and made a minor grammatical change; and, in subsection (j), deleted the subsection catchline, which read: “Investigative authority of the commissioner.”

33-59-8. Advertising.

(a) A registered life settlement broker or licensed provider who is registered or licensed pursuant to this chapter may conduct or participate in advertisements within this state. Such advertisements shall comply with all advertising and marketing laws of this state and rules and regulations promulgated by the Commissioner that are applicable to life insurers or to life settlement brokers and providers licensed pursuant to this chapter.

(b) Advertisements shall be accurate, truthful, and not misleading in fact or by implication.

(c) No person or trust shall:

(1) Directly or indirectly, market, advertise, solicit, or otherwise promote the purchase of a policy for the sole purpose of or with a primary emphasis on settling the policy; or

(2) Use the words “free,” “no cost,” or words of similar import in the marketing, advertising, soliciting, or otherwise promoting of the purchase of a policy. (Code 1981, § 33-59-8, enacted by Ga. L. 2009, p. 370, § 1/SB 61.)

Effective date. — This Code section became effective April 30, 2009, for purposes of promulgating rules and regulations by the Commissioner of Insurance and for all other purposes effective July 1, 2009.

Editor’s notes. — Ga. L. 2009, p. 370, § 1, effective July 1, 2009, redesignated former Code Section 33-59-8 as present Code Section 33-59-9.

33-59-9. Required written disclosures; consequence for failure to provide.

(a) The provider or broker shall provide in writing, in a separate document that is signed by the owner, the following information no later than the date of the application for a life settlement contract:

(1) The fact that possible alternatives to life settlement contracts exist, including, but not limited to, accelerated benefits offered by the issuer of the life insurance policy;

(2) The fact that some or all of the proceeds of a life settlement contract may be taxable and that assistance should be sought from a professional tax adviser;

(3) The fact that the proceeds from a life settlement contract could be subject to the claims of creditors;

(4) The fact that receipt of proceeds from a life settlement contract may adversely affect the recipient's eligibility for public assistance or other government benefits or entitlements and that advice should be obtained from the appropriate agencies;

(5) The fact that the owner has a right to terminate a life settlement contract within 15 days of the date it is executed by all parties and the owner has received the disclosures contained in this Code section. Rescission, if exercised by the owner, is effective only if both notice of the rescission is given and the owner repays all proceeds and any premiums, loans, and loan interest paid on account of the provider within the rescission period. If the insured dies during the rescission period, the contract shall be deemed to have been rescinded subject to repayment by the owner or the owner's estate of all proceeds and any premiums, loans, and loan interest to the provider;

(6) The fact that proceeds will be sent to the owner within three business days after the provider has received the insurer or group administrator's acknowledgment that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated in accordance with the terms of the life settlement contract;

(7) The fact that entering into a life settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy or certificate of a group policy, to be forfeited by the owner and that assistance should be sought from a professional financial adviser;

(8) The method of calculating the compensation paid or to be paid to the life settlement broker or any other person acting for the owner in connection with the transaction, where the term "compensation" includes any thing of value paid or given;

(9) The date by which the funds will be available to the owner and the transmitter of the funds;

(10) The fact that the Commissioner shall require delivery of a buyer's guide or a similar consumer advisory package in the form prescribed by the Commissioner to owners during the solicitation process;

(11) The disclosure document shall contain the following language:

“All medical, financial, or personal information solicited or obtained by a provider or life settlement broker about an insured, including the insured’s identity or the identity of family members, a spouse, or a significant other, may be disclosed as necessary to effect the life settlement contract between the owner and provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years.”;

(12) The fact that the Commissioner shall require providers and life settlement brokers to print separate signed fraud warnings on their applications and on their life settlement contracts as follows:

“Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.”;

(13) The fact that the insured may be contacted by either the provider or life settlement broker or its authorized representative for the purpose of determining the insured’s health status or to verify the insured’s address. This contact is limited to once every three months if the insured has a life expectancy of more than one year and no more than once per month if the insured has a life expectancy of one year or less;

(14) The affiliation, if any, between the provider and the issuer of the insurance policy to be settled;

(15) That a life settlement broker represents exclusively the owner, and not the insurer or the provider or any other person, and owes a fiduciary duty to the owner, including a duty to act according to the owner’s instructions and in the best interest of the owner;

(16) The document shall include the name, address, and telephone number of the provider;

(17) The name, business address, and telephone number of the independent third-party escrow agent, and the fact that the owner may inspect or receive copies of the relevant escrow or trust agreements or documents; and

(18) The fact that a change of ownership could in the future limit the insured’s ability to purchase future insurance on the insured’s life because there is a limit to how much coverage insurers will issue on one life.

(b) The written disclosures shall be conspicuously displayed in any life settlement contract furnished to the owner by a provider including

any affiliations or contractual arrangements between the provider and the life settlement broker.

(c) A life settlement broker shall provide the owner and the provider with at least the following disclosures no later than the date the life settlement contract is signed by all parties. The disclosures shall be conspicuously displayed in the life settlement contract or in a separate document signed by the owner and provide the following information:

(1) The name, business address, and telephone number of the life settlement broker;

(2) A full, complete, and accurate description of all the offers, counter-offers, acceptances, and rejections relating to the proposed life settlement contract;

(3) A written disclosure at the inception of the brokerage arrangement of any affiliations or contractual arrangements between the life settlement broker and any person making an offer in connection with the proposed life settlement contracts;

(4) The name of each life settlement broker who receives compensation and the amount of compensation received by that life settlement broker, which compensation includes any thing of value paid or given to the life settlement broker in connection with the life settlement contract; and

(5) A complete reconciliation of the gross offer or bid by the provider to the net amount of proceeds or value to be received by the owner. For the purpose of this paragraph, "gross offer or bid" means the total amount or value offered by the provider for the purchase of one or more life insurance policies, inclusive of commissions and fees.

(d) The failure to provide the disclosures or rights described in this Code section shall be deemed an unfair trade practice pursuant to Code Section 33-59-17. (Code 1981, § 33-59-8, enacted by Ga. L. 2005, p. 998, § 1/SB 217; Code 1981, § 33-59-9, as redesignated by Ga. L. 2009, p. 370, § 1/SB 61.)

The 2009 amendment, effective April 30, 2009, for purposes of promulgating rules and regulations by the Commissioner of Insurance and for all other purposes effective July 1, 2009, redesignated former Code Section 33-59-8 as present Code Section 33-59-9; rewrote subsection (a); added subsection (b); redesignated former subsection (b) as present subsection (c) and rewrote that subsection; deleted former subsection (c), which read: "If the

life settlement provider transfers ownership or changes the beneficiary of the policy, the life settlement provider shall communicate the change in ownership or beneficiary to the insured within 20 days after the change."; and added subsection (d).

Editor's notes. — Ga. L. 2009, p. 370, § 1, effective July 1, 2009, redesignated former Code Section 33-59-9 as present Code Section 33-59-11.

33-59-10. Lender-financed premiums using policy as collateral; disclosures and certifications.

(a) In addition to other questions an insurance carrier may lawfully pose to a life insurance applicant, insurance carriers may inquire in the application for insurance whether the proposed owner intends to pay premiums with the assistance of financing from a lender that will use the policy as collateral to support the financing.

(b) If, as described in paragraph (11) of Code Section 33-59-2, the loan provides funds which can be used for a purpose other than paying for the premiums, costs, and expenses associated with obtaining and maintaining the life insurance policy and loan, the application shall be rejected as a violation of the prohibited practices in Code Section 33-59-13.

(c) If the financing does not violate Code Section 33-59-13 in this manner, the insurance carrier:

(1) May make disclosures, including, but not limited to, disclosures such as the following, to the applicant and the insured, either on the application or an amendment to the application to be completed no later than the delivery of the policy:

“If you have entered into a loan arrangement where the policy is used as collateral and the policy changes ownership at some point in the future in satisfaction of the loan, the following may be true:

(A) A change of ownership could lead to a stranger owning an interest in the insured’s life;

(B) A change of ownership could in the future limit your ability to purchase future insurance on the insured’s life because there is a limit to how much coverage insurers will issue on one life;

(C) Should there be a change of ownership and you wish to obtain more insurance coverage on the insured’s life in the future, the insured’s higher issue age, a change in health status, or other factors may reduce the ability to obtain coverage or may result in significantly higher premiums; and

(D) You should consult a professional adviser since a change in ownership in satisfaction of the loan may result in tax consequences to the owner, depending on the structure of the loan.”; and

(2) May require certifications, such as the following, from the applicant and the insured:

“(A) I have not entered into any agreement or arrangement providing for the future sale of this life insurance policy;

(B) My loan arrangement for this policy provides funds sufficient to pay for some or all of the premiums, costs, and expenses associated with obtaining and maintaining my life insurance policy, but I have not entered into any agreement by which I am to receive consideration in exchange for procuring this policy; and

(C) The borrower has an insurable interest in the insured.”
(Code 1981, § 33-59-10, enacted by Ga. L. 2009, p. 370, § 1/SB 61.)

Effective date. — This Code section became effective April 30, 2009, for purposes of promulgating rules and regulations by the Commissioner of Insurance and for all other purposes effective July 1, 2009.

Editor’s notes. — Former Code Sec-

tion 33-59-10 (Code 1981, § 33-59-10, enacted by Ga. L. 2005, p. 998, § 1/SB 217), relating to contracts entered into within two years of the issuance of the policy being prohibited, was repealed by Ga. L. 2009, p. 370, § 1, effective July 1, 2009.

33-59-11. Required documents and information; confidentiality; seller’s right to rescind; escrow proceedings; failure to tender consideration; limitation on contracts with the insured for the purpose of determining the insured’s health status.

(a) A provider entering into a life settlement contract, wherein the insured is terminally or chronically ill, shall first obtain:

(1) If the owner is the insured, a written statement from a licensed attending physician that the owner is of sound mind and under no constraint or undue influence to enter into a settlement contract; and

(2) A document in which the insured consents to the release of his or her medical records to a provider, life settlement broker, or insurance producer and, if the policy was issued less than two years from the date of application for a settlement contract, to the insurance company that issued the policy.

(b) The insurer shall respond to a request for verification of coverage submitted by a provider, life settlement broker, or life insurance producer not later than 30 calendar days after the date the request is received. The request for verification of coverage must be made on a form approved by the Commissioner. The insurer shall complete and issue the verification of coverage or indicate in which respects it is unable to respond. In its response, the insurer shall indicate whether, based on the medical evidence and documents provided, the insurer intends to pursue an investigation at this time regarding the validity of the insurance contract.

(c) Before or at the time of execution of the settlement contract, the provider shall obtain a witnessed document in which the owner consents to the settlement contract, represents that the owner has a full

and complete understanding of the settlement contract, represents that the owner has a full and complete understanding of the benefits of the policy, acknowledges that the owner is entering into the settlement contract freely and voluntarily, and, for persons with a terminal or chronic illness or condition, acknowledges that the insured has a terminal or chronic illness and that the terminal or chronic illness or condition was diagnosed after the policy was issued.

(d) The insurer shall not unreasonably delay effecting change of ownership or beneficiary with any life settlement contract lawfully entered into in this state or with a resident of this state.

(e) If a life settlement broker or life insurance producer performs any of these activities required of the provider, the provider is deemed to have fulfilled the requirements of this Code section.

(f) If a life settlement broker performs those verification of coverage activities required of the provider, the provider is deemed to have fulfilled the requirements of subsection (a) of Code Section 33-5-9.

(g) Within 20 days after an owner executes the life settlement contract, the provider shall give written notice to the insurer that issued that insurance policy that the policy has become subject to a life settlement contract. The notice shall be accompanied by the documents required by Code Section 33-59-10.

(h) All medical information solicited or obtained by any licensee shall be subject to the applicable provision of state law relating to confidentiality of medical information if not otherwise provided in this chapter.

(i) All life settlement contracts entered into in this state shall provide that the owner may rescind the contract on or before 15 days after the date it is executed by all parties thereto. Rescission, if exercised by the owner, is effective only if both notice of the rescission is given and the owner repays all proceeds and any premiums, loans, and loan interest paid on account of the provider within the rescission period. If the insured dies during the rescission period, the contract shall be deemed to have been rescinded subject to repayment by the owner or the owner's estate of all proceeds and any premiums, loans, and loan interest to the provider.

(j) Within three business days after receipt from the owner of documents to effect the transfer of the insurance policy, the provider shall pay the proceeds of the settlement to an escrow or trust account managed by a trustee or escrow agent in a state or federally chartered financial institution pending acknowledgment of the transfer by issuer of the policy. The trustee or escrow agent shall be required to transfer the proceeds due to the owner within three business days of acknowledgment of the transfer from the insurer.

(k) Failure to tender the life settlement contract proceeds to the owner by the date disclosed to the owner renders the contract voidable by the owner for lack of consideration until the time the proceeds are tendered to and accepted by the owner. A failure to give written notice of the right of rescission hereunder shall toll the right of rescission until 30 days after the written notice of the right of rescission has been given.

(l) Any fee paid by a provider, party, individual, or an owner to a life settlement broker in exchange for services provided to the owner pertaining to a life settlement contract shall be computed as a percentage of the offer obtained, not the face value of the policy. Nothing in this Code section shall be construed to prohibit a life settlement broker from reducing such life settlement broker's fee below this percentage if the life settlement broker so chooses.

(m) The life settlement broker shall disclose to the owner any thing of value paid or given to a life settlement broker which relates to a life settlement contract.

(n) No person at any time prior to, or at the time of, the application for, or issuance of, a policy, or during a two-year period commencing with the date of issuance of the policy, shall enter into a life settlement contract regardless of the date the compensation is to be provided and regardless of the date the assignment, transfer, sale, devise, bequest, or surrender of the policy is to occur. This prohibition shall not apply if the owner certifies to the provider that:

(1) The policy was issued upon the owner's exercise of conversion rights arising out of a group or individual policy, provided that the total of the time covered under the conversion policy plus the time covered under the prior policy is at least 24 months. The time covered under a group policy shall be calculated without regard to a change in insurance carriers, provided that the coverage has been continuous and under the same group sponsorship; or

(2) The owner submits independent evidence to the provider that one or more of the following conditions have been met within the two-year period:

(A) The owner or insured is terminally or chronically ill;

(B) The owner or insured disposes of his or her ownership interests in a closely held corporation, pursuant to the terms of a buyout or other similar agreement in effect at the time the insurance policy was initially issued;

(C) The owner's spouse dies;

(D) The owner divorces his or her spouse;

(E) The owner retires from full-time employment;

(F) The owner becomes physically or mentally disabled and a physician determines that the disability prevents the owner from maintaining full-time employment; or

(G) A final order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor of the owner, adjudicating the owner bankrupt or insolvent, or approving a petition seeking reorganization of the owner or appointing a receiver, trustee, or liquidator to all or a substantial part of the owner's assets.

Copies of the independent evidence required by paragraph (2) of this subsection shall be submitted to the insurer when the provider submits a request to the insurer for verification of coverage. The copies shall be accompanied by a letter of attestation from the provider that the copies are true and correct copies of the documents received by the provider. Nothing in this Code section shall prohibit an insurer from exercising its right to contest the validity of any policy. If the provider submits to the insurer a copy of independent evidence provided for in paragraph (2) of this subsection when the provider submits a request to the insurer to effect the transfer of the policy to the provider, the copy is deemed to establish that the settlement contract satisfies the requirements of this subsection. (Code 1981, § 33-59-9, enacted by Ga. L. 2005, p. 998, § 1/SB 217; Code 1981, § 33-59-11, as redesignated by Ga. L. 2009, p. 370, § 1/SB 61.)

The 2009 amendment, effective April 30, 2009, for purposes of promulgating rules and regulations by the Commissioner of Insurance and for all other purposes effective July 1, 2009, redesignated former Code Section 33-59-9 as present Code Section 33-59-11; in subsection (a), deleted the paragraph (a)(1) designation, in the introductory paragraph, deleted "life settlement" preceding "provider" and substituted "wherein the insured is terminally or chronically ill, shall first" for "first shall", redesignated subparagraphs (a)(1)(A) and (a)(1)(B) as present paragraphs (a)(1) and (a)(2), respectively, in paragraph (a)(1), substituted "owner" for "seller" twice and deleted "life" preceding "settlement", and, in paragraph (a)(2), substituted "provider, life settlement broker," for "life settlement provider" and deleted "life" preceding "settlement" near the end; redesignated former paragraphs (a)(2) and (a)(3) as present subsections (b) and (c), respectively; in subsection (b), in the first sentence, substituted "provider, life settlement broker," for "life settlement

provider" and substituted "after" for "from", in the second sentence, substituted "must" for "shall", and, in the last sentence, deleted "or possible fraud and shall provide sufficient detail of all reasons for the investigation to the life settlement provider or the life insurance provider" following "contract" at the end; in subsection (c), deleted "life" preceding "settlement" four times, substituted "owner" for "seller" four times, and deleted "life settlement" preceding "provider" near the beginning; deleted former paragraph (a)(4), which read: "If a life insurance producer performs any of these activities required of the life settlement provider, the life settlement provider is deemed to have fulfilled the requirements of this Code section."; added subsections (d) through (g); redesignated former subsections (b) through (e) as present subsections (h) through (k), respectively, and rewrote each of those subsections; deleted former subsection (f); and added subsections (l) through (n).

Editor's notes. — Former Code Sec-

tion 33-59-11 (Code 1981, § 33-59-11, enacted by Ga. L. 2005, p. 998, § 1/SB 217), relating to permissible and impermissible

conduct in advertising, was repealed by Ga. L. 2009, p. 370, § 1, effective July 1, 2009.

33-59-12. Promulgation of regulations; determining governing law when multiple owners.

(a) The Commissioner may promulgate regulations implementing this chapter and regulating the activities and relationships of providers, life settlement brokers, insurers, and their agents subject to statutory limitations on administrative rule making.

(b)(1) If there is more than one owner on a single policy, and the owners are residents of different states, the life settlement contract shall be governed by the law of the state in which the owner having the largest percentage ownership resides or, if the owners hold equal ownership, the state of residence of one owner agreed upon in writing by all of the owners. The law of the state of the insured shall govern in the event that equal owners fail to agree in writing upon a state of residence for jurisdictional purposes.

(2) A provider from this state who enters into a life settlement contract with an owner who is a resident of another state that has enacted statutes or adopted regulations governing life settlement contracts shall be governed in the effectuation of that life settlement contract by the statutes and regulations of the owner's state of residence. If the state in which the owner is a resident has not enacted statutes or regulations governing life settlement contracts, the provider shall give the owner notice that neither state regulates the transaction upon which he or she is entering. For transactions in those states, however, the provider is to maintain all records required if the transactions were executed in the state of residence. The forms used in those states need not be approved by the Commissioner.

(3) If there is a conflict in the laws that apply to an owner and a purchaser in any individual transaction, the laws of the state that apply to the owner shall take precedence and the provider shall comply with those laws. (Code 1981, § 33-59-12, enacted by Ga. L. 2009, p. 370, § 1/SB 61.)

Effective date. — This Code section became effective April 30, 2009, for purposes of promulgating rules and regulations by the Commissioner of Insurance and for all other purposes effective July 1, 2009.

Editor's notes. — Ga. L. 2009, p. 370, § 1, effective July 1, 2009, redesignated former Code Section 33-59-12 as present Code Section 33-59-14.

33-59-13. Unlawful activities deemed fraudulent life settlement act.

(a) It shall be unlawful for any person to:

(1) Enter into a life settlement contract if such person knows or reasonably should have known that the life insurance policy was obtained by means of a false, deceptive, or misleading application for such policy;

(2) Engage in any transaction, practice, or course of business if such person knows or reasonably should have known that the intent was to avoid the notice requirements of this Code section;

(3) Engage in any fraudulent act or practice in connection with any transaction relating to any settlement involving an owner who is a resident of this state;

(4) Issue, solicit, market, or otherwise promote the purchase of an insurance policy for the purpose of or with an emphasis on settling the policy;

(5) Enter into a premium finance agreement with any person or agency, or any person affiliated with such person or agency, pursuant to which such person shall receive any proceeds, fees, or other consideration, directly or indirectly, from the policy or owner of the policy or any other person with respect to the premium finance agreement or any settlement contract or other transaction related to such policy that are in addition to the amounts required to pay the principal, interest, service charges, and any cost or expense incurred by the lender or borrower in connection with the premium finance agreement or subsequent sale of such agreement; provided, further, that any payments, charges, fees, or other amounts in addition to the amounts required to pay the principal, interest, service charges, and any cost or expense incurred by the lender or borrower in connection with the premium finance agreement shall be remitted to the original owner of the policy or to his or her estate if he or she is not living at the time of the determination of the overpayment;

(6) With respect to any settlement contract or insurance policy and a life settlement broker, knowingly solicit an offer from, effectuate a life settlement contract with, or make a sale to any provider, financing entity, or related provider trust that is controlling, controlled by, or under common control with such life settlement broker unless such relationship is disclosed to the owner in accordance with paragraph (3) of subsection (c) of Code Section 33-59-9;

(7) With respect to any life settlement contract or insurance policy and a provider, knowingly enter into a life settlement contract with

an owner, if, in connection with such life settlement contract, any thing of value will be paid to a life settlement broker that is controlling, controlled by, or under common control with such provider or the financing entity or related provider trust that is involved in such settlement contract unless such relationship is disclosed to the owner in accordance with paragraph (3) of subsection (c) of Code Section 33-59-9;

(8) With respect to a provider, enter into a life settlement contract unless the life settlement promotional, advertisement, and marketing materials, as may be prescribed by rule or regulation, have been filed with the Commissioner. In no event shall any marketing materials expressly reference that the insurance is “free” for any period of time. The inclusion of any reference in the marketing materials that would cause an owner to reasonably believe that the insurance is free for any period of time shall be considered a violation of this chapter; or

(9) With respect to any life insurance producer, insurance company, life settlement broker, or provider, make any statement or representation to the applicant or policyholder in connection with the sale or financing of a life insurance policy to the effect that the insurance is free or without cost to the policyholder for any period of time unless provided in the policy.

(b) A violation of this Code section shall be deemed a fraudulent life settlement act. (Code 1981, § 33-59-13, enacted by Ga. L. 2009, p. 370, § 1/SB 61.)

Effective date. — This Code section became effective April 30, 2009, for purposes of promulgating rules and regulations by the Commissioner of Insurance and for all other purposes effective July 1, 2009.

Editor’s notes. — Ga. L. 2009, p. 370, § 1, effective July 1, 2009, redesignated former Code Section 33-59-13 as present Code Section 33-59-15.

33-59-14. Violations; required statement; reporting of fraudulent acts to the Commissioner; immunity for providing information concerning fraudulent acts; confidentiality of documents and evidence; mandatory adoption of antifraud initiatives by providers.

(a)(1) It shall be illegal for a person to commit a fraudulent life settlement act.

(2) A person shall not knowingly and intentionally interfere with the enforcement of the provisions of this chapter or investigations of suspected or actual violations of this chapter.

(3) A person in the business of life settlements shall not knowingly or intentionally permit any person convicted of a felony involving dishonesty or breach of trust to participate in the business of life settlements.

(b)(1) Life settlement contracts and applications for life settlement contracts, regardless of the form of transmission, shall contain the following statement or a substantially similar statement:

“Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines or confinement in prison.”

(2) The lack of a statement as required in paragraph (1) of this subsection does not constitute a defense in any prosecution for a fraudulent life settlement act.

(c)(1) Any person engaged in the business of life settlements having knowledge or a reasonable belief that a fraudulent life settlement act is being, will be, or has been committed shall provide to the Commissioner the information required by, and in a manner prescribed by, the Commissioner.

(2) Any other person having knowledge or a reasonable belief that a fraudulent life settlement act is being, will be, or has been committed may provide to the Commissioner the information required by, and in a manner prescribed by, the Commissioner.

(d)(1) No civil liability shall be imposed on and no cause of action shall arise from a person's furnishing information concerning suspected, anticipated, or completed fraudulent life settlement acts or suspected or completed fraudulent insurance acts if the information is provided to or received from:

(A) The Commissioner or the Commissioner's employees, agents, or representatives;

(B) Federal, state, or local law enforcement or regulatory officials or their employees, agents, or representatives;

(C) A person involved in the prevention and detection of fraudulent life settlement acts or that person's agents, employees, or representatives;

(D) Any regulatory body or their employees, agents, or representatives overseeing life insurance or life settlements, securities, or investment fraud;

(E) The life insurer that issued the life insurance policy covering the life of the insured; or

(F) The licensee and any agents, employees, or representatives.

(2) Paragraph (1) of this subsection shall not apply to statements made with actual malice. In an action brought against a person for filing a report or furnishing other information concerning a fraudulent life settlement act or a fraudulent insurance act, the party bringing the action shall plead specifically any allegation that paragraph (1) of this subsection does not apply because the person filing the report or furnishing the information did so with actual malice.

(3) A person identified in paragraph (1) of this subsection shall be entitled to an award of attorney's fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander, or any other relevant tort arising out of activities in carrying out the provisions of this chapter and the party bringing the action was not substantially justified in doing so. For purposes of this paragraph, a proceeding is substantially justified if it had a reasonable basis in law or fact at the time that it was initiated.

(4) This subsection does not abrogate or modify common law or statutory privileges or immunities enjoyed by a person described in paragraph (1) of this subsection.

(e)(1) The documents and evidence provided pursuant to subsection (d) of this Code section or obtained by the Commissioner in an investigation of suspected or actual fraudulent life settlement acts shall be privileged and confidential and shall not be a public record and shall not be subject to discovery or subpoena in a civil or criminal action.

(2) Paragraph (1) of this subsection shall not prohibit release by the Commissioner of documents and evidence obtained in an investigation of suspected or actual fraudulent life settlement acts:

(A) In administrative or judicial proceedings to enforce laws administered by the Commissioner;

(B) To federal, state, or local law enforcement or regulatory agencies, to an organization established for the purpose of detecting and preventing fraudulent life settlement acts, or to the National Association of Insurance Commissioners; or

(C) At the discretion of the Commissioner, to a person in the business of life settlements that is aggrieved by a fraudulent life settlement act.

(3) Release of documents and evidence under paragraph (2) of this subsection does not abrogate or modify the privilege granted in paragraph (1) of this subsection.

(f) This chapter shall not:

(1) Preempt the authority or relieve the duty of other law enforcement or regulatory agencies to investigate, examine, and prosecute suspected violations of law;

(2) Preempt, supersede, or limit any provision of any state securities law or any rule, order, or notice issued thereunder;

(3) Prevent or prohibit a person from disclosing voluntarily information concerning life settlement fraud to a law enforcement or regulatory agency other than the department; or

(4) Limit the powers granted elsewhere by the laws of this state to the Commissioner or an insurance fraud unit to investigate and examine possible violations of law and to take appropriate action against wrongdoers.

(g)(1) Providers and life settlement brokers shall have in place antifraud initiatives reasonably calculated to detect, prosecute, and prevent fraudulent life settlement acts. At the discretion of the Commissioner, the Commissioner may order, or a licensee may request and the Commissioner may grant, such modifications of the following required initiatives as necessary to ensure an effective antifraud program. The modifications may be more or less restrictive than the required initiatives so long as the modifications may reasonably be expected to accomplish the purpose of this subsection. Antifraud initiatives shall include:

(A) Fraud investigators, who may be provider or life settlement broker employees or independent contractors; and

(B) An antifraud plan, which shall be submitted to the Commissioner. The antifraud plan shall include, but not be limited to:

(i) A description of the procedures for detecting and investigating possible fraudulent life settlement acts and procedures for resolving material inconsistencies between medical records and insurance applications;

(ii) A description of the procedures for reporting possible fraudulent life settlement acts to the Commissioner;

(iii) A description of the plan for antifraud education and training of underwriters and other personnel; and

(iv) A description or chart outlining the organizational arrangement of the antifraud personnel who are responsible for the investigation and reporting of possible fraudulent life settlement acts and investigating unresolved material inconsistencies between medical records and insurance applications.

(2) Antifraud plans submitted to the Commissioner shall be privileged and confidential and shall not be a public record and shall not

be subject to discovery or subpoena in a civil or criminal action. (Code 1981, § 33-59-12, enacted by Ga. L. 2005, p. 998, § 1/SB 217; Code 1981, § 33-59-14, as redesignated by Ga. L. 2009, p. 370, § 1/SB 61.)

The 2009 amendment, effective April 30, 2009, for purposes of promulgating rules and regulations by the Commissioner of Insurance and for all other purposes effective July 1, 2009, redesignated former Code Section 33-59-12 as present Code Section 33-59-14; in subsection (a), in paragraph (a)(1), substituted “It shall be illegal for a person to” for “A person shall not” near the beginning, in paragraph (a)(2), substituted “shall not knowingly and intentionally” for “, knowingly or intentionally, shall not” near the beginning, and, in paragraph (a)(3), substituted “settlements shall not” for “settlements,” and substituted “intentionally permit any person” for “intentionally, shall not permit a person”; in subsection (b), in paragraph (b)(1), substituted “Life settlement contracts and applications for life settlement contracts” for “A life settlement contract and an application for a life settlement contract” at the beginning, in the undesignated paragraph, deleted “, upon conviction,” following “crime and” and deleted “, or both” following “prison” at the end, and, in paragraph (b)(2), substituted “required” for “provided for” near the be-

ginning; in subsection (c), in paragraph (c)(1), substituted “Any person” for “A person” at the beginning and inserted two commas and, in paragraph (c)(2), substituted “Any other” for “Another” at the beginning and inserted two commas; rewrote subsection (d); in subsection (e), in paragraph (e)(1), substituted “shall be” for “are” and substituted “shall not be” for “are not” twice, in paragraph (e)(2), substituted “shall not” for “does not” in the beginning, and, in paragraph (e)(3), substituted “under paragraph (2)” for “provided by paragraph (2)”; in subsection (f), in the introductory paragraph, substituted “shall not” for “does not” at the end, added paragraph (f)(2), redesignated former paragraphs (f)(2) and (f)(3) as present paragraphs (f)(3) and (f)(4), respectively, and, in paragraph (f)(3), substituted “life settlement fraud” for “fraudulent life settlement acts” and deleted “insurance” preceding “department” near the end; and rewrote subsection (g).

Editor’s notes. — Ga. L. 2009, p. 370, § 1, effective July 1, 2009, redesignated former Code Section 33-59-14 as present Code Section 33-59-17.

33-59-15. Remedies and penalties for violations; procedural issues.

(a) In addition to the penalties and other enforcement provisions of this chapter, if any person violates this chapter or any rule or regulation implementing this chapter, the Commissioner may seek an injunction in a court of competent jurisdiction in the county where the person resides or has a principal place of business and may apply for temporary and permanent orders as the Commissioner determines necessary to restrain the person from further committing the violation.

(b) Any person damaged by the acts of any other person in violation of this chapter or any rule or regulation implementing this chapter may bring a civil action for damages against the person committing the violation in a court of competent jurisdiction.

(c) The Commissioner may issue a cease and desist order upon a person who violates any provision of this chapter, any rule, regulation, or order adopted by the Commissioner, or any written agreement

entered into with the Commissioner, in accordance with Chapter 2 of this title.

(d) When the Commissioner finds that such an action presents an immediate danger to the public and requires an immediate final order, he or she may issue an emergency cease and desist order reciting with particularity the facts underlying such findings. The emergency cease and desist order shall become effective immediately upon service of a copy of the order on the respondent and shall remain effective for 90 days. If the department begins nonemergency cease and desist proceedings under subsection (a) of this Code section, the emergency cease and desist order shall remain effective, absent an order by an appellate court of competent jurisdiction pursuant to Chapter 13 of Title 50. In the event of a willful violation of this chapter, the trial court may award statutory damages in addition to actual damages in an additional amount up to three times the actual damage award. The provisions of this chapter may not be waived by agreement. No choice of law provision may be utilized to prevent the application of this chapter to any settlement in which a party to the settlement is a resident of this state. (Code 1981, § 33-59-13, enacted by Ga. L. 2005, p. 998, § 1/SB 217; Code 1981, § 33-59-15, as redesignated by Ga. L. 2009, p. 370, § 1/SB 61.)

The 2009 amendment, effective April 30, 2009, for purposes of promulgating rules and regulations by the Commissioner of Insurance and for all other purposes effective July 1, 2009, redesignated former Code Section 33-59-13 as present Code Section 33-59-15; in subsection (a), substituted “any” for “a”, substituted “this chapter or any rule or” for “the provisions of this chapter or any”, inserted “in the county where the person resides or has a principal place of business”, deleted “are” preceding “necessary”, and inserted “further” near the end; in subsection (b), substituted “Any person” for “A person”, substituted “any other person” for “a person”,

inserted “or any rules or regulation implementing this chapter”, and inserted “for damages”; in subsection (c), deleted “, in accordance with Code Section 33-2-24,” following “issue”, substituted “who violates” for “that violates”, substituted “rule, regulation,” for “regulation”, and added “, in accordance with Chapter 2 of this title” at the end; rewrote subsection (d); and deleted former subsections (e) and (f).

Editor’s notes. — Former Code Section 33-59-15 (Code 1981, § 33-59-15, enacted by Ga. L. 2005, p. 998, § 1/SB 217), relating to the authority of the commissioner, was repealed by Ga. L. 2009, p. 370, § 1, effective July 1, 2009.

33-59-16. Fraudulent life settlement acts prohibited; criminal and civil penalties; revocation of license.

(a) It is a violation of this chapter for any person, provider, life settlement broker, or any other party related to the business of life settlements to commit a fraudulent life settlement act.

(b) For criminal liability purposes, a person that commits a fraudulent life settlement act shall be guilty of committing insurance fraud and shall be guilty of a felony and, upon conviction, shall be punished

by imprisonment for not less than two nor more than ten years, or by a fine of not more than \$10,000.00, or both.

(c) The Commissioner shall be empowered to levy a civil penalty:

(1) Not exceeding \$1,000.00 for each and every act in violation of this chapter or, if the person knew or reasonably should have known the acts that he or she committed were in violation of this chapter, the monetary penalty provided for in this subsection may be increased to an amount up to \$5,000.00 for each and every act in violation; and

(2) The amount of the claim for each violation upon any person, including those persons and their employees licensed pursuant to this chapter, who is found to have committed a fraudulent life settlement act or violated any other provision of this chapter.

(d) The license of a person licensed under this chapter that commits a fraudulent life settlement act shall be revoked for a period of at least one year. (Code 1981, § 33-59-16, enacted by Ga. L. 2009, p. 370, § 1/SB 61.)

Effective date. — This Code section became effective April 30, 2009, for purposes of promulgating rules and regulations by the Commissioner of Insurance and for all other purposes effective July 1, 2009.

Editor's notes. — Former Code Sec-

tion 33-59-16 (Code 1981, § 33-59-16, enacted by Ga. L. 2005, p. 998, § 1/SB 217; Ga. L. 2008, p. 381, § 10/SB 358), relating to compliance with security laws, was repealed by Ga. L. 2009, p. 370, § 1, effective July 1, 2009.

33-59-17. Unfair trade practice.

A violation of this chapter shall be considered an unfair trade practice pursuant to state law and subject to the penalties provided by state law. (Code 1981, § 33-59-14, enacted by Ga. L. 2005, p. 998, § 1/SB 217; Code 1981, § 33-59-17, as redesignated by Ga. L. 2009, p. 370, § 1/SB 61.)

The 2009 amendment, effective April 30, 2009, for purposes of promulgating rules and regulations by the Commissioner of Insurance and for all other purposes effective July 1, 2009, redesignated former Code Section 33-59-14 as present Code Section 33-59-17; substituted “pursuant to state law” for “under Chapter 6 of

this title”; and substituted “provided by state law” for “contained in that chapter” at the end.

Editor's notes. — Ga. L. 2009, p. 370, § 1, effective July 1, 2009, redesignated former Code Section 33-59-17 as present Code Section 33-59-18.

33-59-18. Transacting business permitted while the provider's license application is pending.

(a) A provider lawfully transacting business in this state prior to July 1, 2009, may continue to do so pending approval or disapproval of

that person's application for a license so long as the application is filed with the Commissioner not later than 30 days after publication by the Commissioner of an application form and instructions for licensure of providers. If the publication of the application form and instructions is prior to July 1, 2009, then the filing of the application shall not be later than August 1, 2009. During the time that such an application is pending with the Commissioner, the applicant may use any form of life settlement contract that has been filed with the Commissioner pending approval thereof, provided that such form is otherwise in compliance with the provisions of this chapter. Any person transacting business in this state under this provision shall be obligated to comply with all other requirements of this chapter.

(b) A person who has lawfully negotiated life settlement contracts between any owner residing in this state and one or more providers for at least one year immediately prior to July 1, 2009, may continue to do so pending approval or disapproval of that person's application for a license so long as the application is filed with the Commissioner not later than 30 days after publication by the Commissioner of an application form and instructions for registration of life settlement brokers. If the publication of the application form and instructions is prior to July 1, 2009, then the filing of the application shall not be later than August 1, 2009. Any person transacting business in this state under this provision shall be obligated to comply with all other requirements of this chapter. (Code 1981, § 33-59-17, enacted by Ga. L. 2005, p. 998, § 1/SB 217; Code 1981, § 33-59-18, as redesignated by Ga. L. 2009, p. 370, § 1/SB 61.)

The 2009 amendment, effective April 30, 2009, for purposes of promulgating rules and regulations by the Commissioner of Insurance and for all other purposes effective July 1, 2009, redesignated former Code Section 33-59-17 as present Code Section 33-59-18; designated the existing provisions as subsection (a); in subsection (a), in the first sentence, deleted "life settlement" preceding "provider", inserted "prior to July 1, 2009," substituted "that person's" for "the person's", inserted "and instructions", and deleted "these life settlement" preceding "providers" at the end, in the second sentence, inserted "and instructions", substituted "July 1, 2009," for "November 5, 2005," and substituted "August 1, 2009" for "30 days after No-

vember 5, 2005" at the end, and added the last two sentences; and added subsection (b).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2009, "to" was inserted in the second sentence of subsection (b).

Editor's notes. — Former Code Section 33-59-18 (Code 1981, § 33-59-18, enacted by Ga. L. 2005, p. 998, § 1/SB 217), relating to the one-year exception to license requirement for persons who have lawfully negotiated life settlement contracts for at least one year and registration with the Commissioner and compliance with security laws, was repealed by Ga. L. 2009, p. 370, § 1, effective July 1, 2009.

CHAPTER 59A

INTERSTATE INSURANCE PRODUCT REGULATION
COMPACT

Sec.		Insurance Product Regulation
33-59A-1.	Compact enacted and entered into by the State of Georgia; text of compact.	Commission; Commissioner of Insurance to be state's representative.
33-59A-2.	Membership on Interstate In-	

Effective date. — This chapter became effective July 1, 2006. 59, as enacted by Ga. L. 2006, p. 1033, § 1/SB 384, was redesignated as Chapter 59A.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2006, Chapter

33-59A-1. Compact enacted and entered into by the State of Georgia; text of compact.

The Interstate Insurance Product Regulation Compact is enacted into law and entered into by this state with all other jurisdictions legally joining therein in the form substantially as follows:

INTERSTATE INSURANCE PRODUCT REGULATION COMPACT

Article I. Purposes.

The purposes of this Interstate Insurance Product Regulation Compact are, through means of joint and cooperative action among the Compacting States:

- (1) To promote and protect the interest of consumers of individual and group annuity, life insurance, disability income and long-term care insurance products;
- (2) To develop uniform standards for insurance products covered under the Compact;
- (3) To establish a central clearinghouse to receive and provide prompt review of insurance products covered under the Compact and, in certain cases, advertisements related thereto, submitted by insurers authorized to do business in one or more Compacting States;
- (4) To give appropriate regulatory approval to those product filings and advertisements satisfying the applicable uniform standard;
- (5) To improve coordination of regulatory resources and expertise between state insurance departments regarding the setting of uniform standards and review of insurance products covered under the Compact;

- (6) To create the Interstate Insurance Product Regulation Commission; and
- (7) To perform these and such other related functions as may be consistent with the state regulation of the business of insurance.

Article II. Definitions.

For purposes of this Compact:

- (1) "Advertisement" means any material designed to create public interest in a Product, or induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace or retain a policy, as more specifically defined in the Rules and Operating Procedures of the Commission.
- (2) "Bylaws" mean those bylaws established by the Commission for its governance, or for directing or controlling the Commission's actions or conduct.
- (3) "Compacting State" means any State which has enacted this Compact legislation and which has not withdrawn pursuant to Article XIV, Section 1, or been terminated pursuant to Article XIV, Section 2.
- (4) "Commission" means the Interstate Insurance Product Regulation Commission established by this Compact.
- (5) "Commissioner" means the chief insurance regulatory official of a State including, but not limited to, commissioner, superintendent, director or administrator.
- (6) "Domiciliary State" means the state in which an Insurer is incorporated or organized, or, in the case of an alien Insurer, its state of entry.
- (7) "Insurer" means any entity licensed by a State to issue contracts of insurance for any of the lines of insurance covered by this Act.
- (8) "Member" means the person chosen by a Compacting State as its representative to the Commission, or his or her designee.
- (9) "Noncompacting State" means any State which is not at the time a Compacting State.
- (10) "Operating Procedures" mean procedures promulgated by the Commission implementing a Rule, Uniform Standard, or a provision of this Compact.
- (11) "Product" means the form of a policy or contract, including any application, endorsement, or related form which is attached to and made a part of the policy or contract, and any evidence of coverage or certificate, for an individual or group annuity, life insurance, disability

income, or long-term care insurance product that an Insurer is authorized to issue.

(12) “Rule” means a statement of general or particular applicability and future effect promulgated by the Commission, including a Uniform Standard developed pursuant to Article VII of this Compact, designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of the Commission, which shall have the force and effect of law in the Compacting States.

(13) “State” means any state, district, or territory of the United States of America.

(14) “Third-Party Filer” means an entity that submits a Product filing to the Commission on behalf of an Insurer.

(15) “Uniform Standard” means a standard adopted by the Commission for a Product line, pursuant to Article VII of this Compact, and shall include all of the Product requirements in aggregate; provided, that each Uniform Standard shall be construed, whether express or implied, to prohibit the use of any inconsistent, misleading, or ambiguous provisions in a Product and the form of the Product made available to the public shall not be unfair, inequitable, or against public policy as determined by the Commission.

Article III. Establishment of the Commission and Venue.

(1) The Compacting States hereby create and establish a joint public agency known as the “Interstate Insurance Product Regulation Commission.” Pursuant to Article IV, the Commission will have the power to develop Uniform Standards for Product lines, receive and provide prompt review of Products filed therewith, and give approval to those Product filings satisfying applicable Uniform Standards; provided, it is not intended for the Commission to be the exclusive entity for receipt and review of insurance product filings. Nothing herein shall prohibit any Insurer from filing its product in any State wherein the Insurer is licensed to conduct the business of insurance; and any such filing shall be subject to the laws of the State where filed.

(2) The Commission is a body corporate and politic, and an instrumentality of the Compacting States.

(3) The Commission is solely responsible for its liabilities except as otherwise specifically provided in this Compact.

(4) Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a Court of competent jurisdiction where the principal office of the Commission is located.

Article IV. Powers of the Commission.

The Commission shall have the following powers:

(1) To promulgate Rules, pursuant to Article VII of this Compact, which shall have the force and effect of law and shall be binding in the Compacting States to the extent and in the manner provided in this Compact;

(2) To exercise its rulemaking authority and establish reasonable Uniform Standards for Products covered under the Compact, and Advertisement related thereto, which shall have the force and effect of law and shall be binding in the Compacting States, but only for those Products filed with the Commission, provided, that a Compacting State shall have the right to opt out of such Uniform Standard pursuant to Article VII, to the extent and in the manner provided in this Compact, and, provided further, that any Uniform Standard established by the Commission for long-term care insurance products may provide the same or greater protections for consumers as, but shall not provide less than, those protections set forth in the National Association of Insurance Commissioners' Long-Term Care Insurance Model Act and Long-Term Care Insurance Model Regulation, respectively, adopted as of 2001. The Commission shall consider whether any subsequent amendments to the NAIC Long-Term Care Insurance Model Act or Long-Term Care Insurance Model Regulation adopted by the NAIC require amending of the Uniform Standards established by the Commission for long-term care insurance products;

(3) To receive and review in an expeditious manner Products filed with the Commission, and rate filings for disability income and long-term care insurance Products, and give approval of those Products and rate filings that satisfy the applicable Uniform Standard, where such approval shall have the force and effect of law and be binding on the Compacting States to the extent and in the manner provided in the Compact;

(4) To receive and review in an expeditious manner Advertisement relating to long-term care insurance products for which Uniform Standards have been adopted by the Commission, and give approval to all Advertisement that satisfies the applicable Uniform Standard. For any product covered under this Compact, other than long-term care insurance products, the Commission shall have the authority to require an insurer to submit all or any part of its Advertisement with respect to that product for review or approval prior to use, if the Commission determines that the nature of the product is such that an Advertisement of the product could have the capacity or tendency to mislead the public. The actions of Commission as provided in this section shall have the force and effect of law and shall be binding in the Compacting States to the extent and in the manner provided in the Compact;

(5) To exercise its rule-making authority and designate Products and Advertisement that may be subject to a self-certification process without the need for prior approval by the Commission.

(6) To promulgate Operating Procedures, pursuant to Article VII of this Compact, which shall be binding in the Compacting States to the extent and in the manner provided in this Compact;

(7) To bring and prosecute legal proceedings or actions in its name as the Commission; provided, that the standing of any state insurance department to sue or be sued under applicable law shall not be affected;

(8) To issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence;

(9) To establish and maintain offices;

(10) To purchase and maintain insurance and bonds;

(11) To borrow, accept, or contract for services of personnel, including, but not limited to, employees of a Compacting State;

(12) To hire employees, professionals, or specialists, and elect or appoint officers, and to fix their compensation, define their duties, and give them appropriate authority to carry out the purposes of the Compact, and determine their qualifications; and to establish the Commission's personnel policies and programs relating to, among other things, conflicts of interest, rates of compensation, and qualifications of personnel;

(13) To accept any and all appropriate donations and grants of money, equipment, supplies, materials, and services, and to receive, utilize, and dispose of the same; provided that at all times the Commission shall strive to avoid any appearance of impropriety;

(14) To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve, or use, any property, real, personal, or mixed; provided that at all times the Commission shall strive to avoid any appearance of impropriety;

(15) To sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed;

(16) To remit filing fees to Compacting States as may be set forth in the Bylaws, Rules, or Operating Procedures;

(17) To enforce compliance by Compacting States with Rules, Uniform Standards, Operating Procedures, and Bylaws;

(18) To provide for dispute resolution among Compacting States;

(19) To advise Compacting States on issues relating to Insurers domiciled or doing business in Noncompacting jurisdictions, consistent with the purposes of this Compact;

(20) To provide advice and training to those personnel in state insurance departments responsible for product review, and to be a resource for state insurance departments;

- (21) To establish a budget and make expenditures;
- (22) To borrow money;
- (23) To appoint committees, including advisory committees comprising Members, state insurance regulators, state legislators or their representatives, insurance industry and consumer representatives, and such other interested persons as may be designated in the Bylaws;
- (24) To provide and receive information from, and to cooperate with law enforcement agencies;
- (25) To adopt and use a corporate seal; and
- (26) To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of the business of insurance.

Article V. Organization of the Commission.

(1) Membership, Voting, and Bylaws.

(a) Each Compacting State shall have and be limited to one Member. Each Member shall be qualified to serve in that capacity pursuant to applicable law of the Compacting State. Any Member may be removed or suspended from office as provided by the law of the State from which he or she shall be appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the Compacting State wherein the vacancy exists. Nothing herein shall be construed to affect the manner in which a Compacting State determines the election or appointment and qualification of its own Commissioner.

(b) Each Member shall be entitled to one vote and shall have an opportunity to participate in the governance of the Commission in accordance with the Bylaws. Notwithstanding any provision herein to the contrary, no action of the Commission with respect to the promulgation of a Uniform Standard shall be effective unless two-thirds (2/3) of the Members vote in favor thereof.

(c) The Commission shall, by a majority of the Members, prescribe Bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes, and exercise the powers, of the Compact, including, but not limited to:

- (i) Establishing the fiscal year of the Commission;
- (ii) Providing reasonable procedures for appointing and electing members, as well as holding meetings, of the Management Committee;
- (iii) Providing reasonable standards and procedures: (i) for the establishment and meetings of other committees, and (ii) governing

any general or specific delegation of any authority or function of the Commission;

(iv) Providing reasonable procedures for calling and conducting meetings of the Commission that consists of a majority of Commission members, ensuring reasonable advance notice of each such meeting and providing for the right of citizens to attend each such meeting with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and insurers' proprietary information, including trade secrets. The Commission may meet in camera only after a majority of the entire membership votes to close a meeting en toto or in part. As soon as practicable, the Commission must make public (i) a copy of the vote to close the meeting revealing the vote of each Member with no proxy votes allowed, and (ii) votes taken during such meeting;

(v) Establishing the titles, duties, and authority and reasonable procedures for the election of the officers of the Commission;

(vi) Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar laws of any Compacting State, the Bylaws shall exclusively govern the personnel policies and programs of the Commission;

(vii) Promulgating a code of ethics to address permissible and prohibited activities of commission members and employees; and

(viii) Providing a mechanism for winding up the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of the Compact after the payment and/or reserving of all of its debts and obligations.

(d) The Commission shall publish its bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto, with the appropriate agency or officer in each of the Compacting States.

(2) Management Committee, Officers, and Personnel.

(a) A Management Committee comprising no more than fourteen (14) members shall be established as follows:

(i) One (1) member from each of the six (6) Compacting States with the largest premium volume for individual and group annuities, life, disability income, and long-term care insurance products, determined from the records of the NAIC for the prior year;

(ii) Four (4) members from those Compacting States with at least two percent (2%) of the market based on the premium volume described above, other than the six (6) Compacting States with the

largest premium volume, selected on a rotating basis as provided in the Bylaws; and

(iii) Four (4) members from those Compacting States with less than two percent (2%) of the market, based on the premium volume described above, with one (1) selected from each of the four (4) zone regions of the NAIC as provided in the Bylaws.

(b) The Management Committee shall have such authority and duties as may be set forth in the Bylaws, including but not limited to:

(i) Managing the affairs of the Commission in a manner consistent with the Bylaws and purposes of the Commission;

(ii) Establishing and overseeing an organizational structure within, and appropriate procedures for, the Commission to provide for the creation of Uniform Standards and other Rules, receipt and review of product filings, administrative and technical support functions, review of decisions regarding the disapproval of a product filing, and the review of elections made by a Compacting State to opt out of a Uniform Standard; provided that a Uniform Standard shall not be submitted to the Compacting States for adoption unless approved by two-thirds (2/3) of the members of the Management Committee;

(iii) Overseeing the offices of the Commission; and

(iv) Planning, implementing, and coordinating communications and activities with other state, federal, and local government organizations in order to advance the goals of the Commission.

(c) The Commission shall elect annually officers from the Management Committee, with each having such authority and duties, as may be specified in the Bylaws.

(d) The Management Committee may, subject to the approval of the Commission, appoint or retain an executive director for such period, upon such terms and conditions and for such compensation as the Commission may deem appropriate. The executive director shall serve as secretary to the Commission, but shall not be a Member of the Commission. The executive director shall hire and supervise such other staff as may be authorized by the Commission.

(3) Legislative and Advisory Committees.

(a) A legislative committee comprising state legislators or their designees shall be established to monitor the operations of, and make recommendations to, the Commission, including the Management Committee; provided that the manner of selection and term of any legislative committee member shall be as set forth in the Bylaws. Prior to the adoption by the Commission of any Uniform Standard,

revision to the Bylaws, annual budget, or other significant matter as may be provided in the Bylaws, the Management Committee shall consult with and report to the legislative committee.

(b) The Commission shall establish two (2) advisory committees, one of which shall comprise consumer representatives independent of the insurance industry, and the other comprising insurance industry representatives.

(c) The Commission may establish additional advisory committees as its Bylaws may provide for the carrying out of its functions.

(4) Corporate Records of the Commission.

The Commission shall maintain its corporate books and records in accordance with the Bylaws.

(5) Qualified Immunity, Defense, and Indemnification.

(a) The Members, officers, executive director, employees, and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities; provided, that nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of that person.

(b) The Commission shall defend any Member, officer, executive director, employee, or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities; provided, that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further, that the actual or alleged act, error, or omission did not result from that person's intentional or willful and wanton misconduct.

(c) The Commission shall indemnify and hold harmless any Member, officer, executive director, employee, or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that such person had a reasonable basis

for believing occurred within the scope of Commission employment, duties, or responsibilities, provided, that the actual or alleged act, error, or omission did not result from the intentional or willful and wanton misconduct of that person.

Article VI. Meetings and Acts of the Commission.

(1) The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the Bylaws.

(2) Each Member of the Commission shall have the right and power to cast a vote to which that Compacting State is entitled and to participate in the business and affairs of the Commission. A Member shall vote in person or by such other means as provided in the Bylaws. The Bylaws may provide for Members' participation in meetings by telephone or other means of communication.

(3) The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the Bylaws.

RULEMAKING FUNCTIONS OF THE COMMISSION AND OPTING OUT OF UNIFORM STANDARDS

Article VII. Rules and Operating Procedures.

(1) **Rulemaking Authority.** The Commission shall promulgate reasonable Rules, including Uniform Standards, and Operating Procedures in order to effectively and efficiently achieve the purposes of this Compact. Notwithstanding the foregoing, in the event the Commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of this Compact, or the powers granted hereunder, then such an action by the Commission shall be invalid and have no force and effect.

(2) **Rulemaking Procedure.** Rules and Operating Procedures shall be made pursuant to a rulemaking process that conforms to the Model State Administrative Procedure Act of 1981, as amended, as may be appropriate to the operations of the Commission. Before the Commission adopts a Uniform Standard, the Commission shall give written notice to the relevant state legislative committee(s) in each Compacting State responsible for insurance issues of its intention to adopt the Uniform Standard. The Commission in adopting a Uniform Standard shall consider fully all submitted materials and issue a concise explanation of its decision.

(3) **Effective Date and Opt Out of a Uniform Standard.** A Uniform Standard shall become effective ninety (90) days after its promulgation by the Commission or such later date as the Commission may determine; provided, however, that a Compacting State may opt

out of a Uniform Standard as provided in this Article. "Opt out" shall be defined as any action by a Compacting State to decline to adopt or participate in a promulgated Uniform Standard. All other Rules and Operating Procedures, and amendments thereto, shall become effective as of the date specified in each Rule, Operating Procedure, or amendment.

(4) **Opt Out Procedure.** A Compacting State may opt out of a Uniform Standard, either by legislation or regulation duly promulgated by the Insurance Department under the Compacting State's Administrative Procedure Act. If a Compacting State elects to opt out of a Uniform Standard by regulation, it must (a) give written notice to the Commission no later than ten (10) business days after the Uniform Standard is promulgated, or at the time the State becomes a Compacting State and (b) find that the Uniform Standard does not provide reasonable protections to the citizens of the State, given the conditions in the State. The Commissioner shall make specific findings of fact and conclusions of law, based on a preponderance of the evidence, detailing the conditions in the State which warrant a departure from the Uniform Standard and determining that the Uniform Standard would not reasonably protect the citizens of the State. The Commissioner must consider and balance the following factors and find that the conditions in the State and needs of the citizens of the State outweigh: (i) the intent of the legislature to participate in, and the benefits of, an interstate agreement to establish national uniform consumer protections for the Products subject to this Compact; and (ii) the presumption that a Uniform Standard adopted by the Commission provides reasonable protections to consumers of the relevant Product.

Notwithstanding the foregoing, a Compacting State may, at the time of its enactment of this Compact, prospectively opt out of all Uniform Standards involving long-term care insurance products by expressly providing for such opt out in the enacted Compact, and such an opt out shall not be treated as a material variance in the offer or acceptance of any State to participate in this Compact. Such an opt out shall be effective at the time of enactment of this Compact by the Compacting State and shall apply to all existing Uniform Standards involving long-term care insurance products and those subsequently promulgated.

(5) **Effect of Opt Out.** If a Compacting State elects to opt out of a Uniform Standard, the Uniform Standard shall remain applicable in the Compacting State electing to opt out until such time the opt out legislation is enacted into law or the regulation opting out becomes effective.

Once the opt out of a Uniform Standard by a Compacting State becomes effective as provided under the laws of that State, the Uniform

Standard shall have no further force and effect in that State unless and until the legislation or regulation implementing the opt out is repealed or otherwise becomes ineffective under the laws of the State. If a Compacting State opts out of a Uniform Standard after the Uniform Standard has been made effective in that State, the opt out shall have the same prospective effect as provided under Article XIV for withdrawals.

(6) **Stay of Uniform Standard.** If a Compacting State has formally initiated the process of opting out of a Uniform Standard by regulation, and, while the regulatory opt out is pending, the Compacting State may petition the Commission, at least fifteen (15) days before the effective date of the Uniform Standard, to stay the effectiveness of the Uniform Standard in that State. The Commission may grant a stay if it determines the regulatory opt out is being pursued in a reasonable manner and there is a likelihood of success. If a stay is granted or extended by the Commission, the stay or extension thereof may postpone the effective date by up to ninety (90) days, unless affirmatively extended by the Commission; provided, a stay may not be permitted to remain in effect for more than one (1) year unless the Compacting State can show extraordinary circumstances which warrant a continuance of the stay, including, but not limited to, the existence of a legal challenge which prevents the Compacting State from opting out. A stay may be terminated by the Commission upon notice that the rulemaking process has been terminated.

(7) Not later than thirty (30) days after a Rule or Operating Procedure is promulgated, any person may file a petition for judicial review of the Rule or Operating Procedure; provided, that the filing of such a petition shall not stay or otherwise prevent the Rule or Operating Procedure from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the Commission consistent with applicable law and shall not find the Rule or Operating Procedure to be unlawful if the Rule or Operating Procedure represents a reasonable exercise of the Commission's authority.

Article VIII. Commission Records and Enforcement.

(1) The Commission shall promulgate Rules establishing conditions and procedures for public inspection and copying of its information and official records, except such information and records involving the privacy of individuals and insurers' trade secrets. The Commission may promulgate additional Rules under which it may make available to federal and state agencies, including law enforcement agencies, records and information otherwise exempt from disclosure, and may enter into agreements with such agencies to receive or exchange information or records subject to nondisclosure and confidentiality provisions.

(2) Except as to privileged records, data, and information, the laws of any Compacting State pertaining to confidentiality or nondisclosure shall not relieve any Compacting State Commissioner of the duty to disclose any relevant records, data, or information to the Commission; provided, that disclosure to the Commission shall not be deemed to waive or otherwise affect any confidentiality requirement; and further provided, that, except as otherwise expressly provided in this Act, the Commission shall not be subject to the Compacting State's laws pertaining to confidentiality and nondisclosure with respect to records, data, and information in its possession. Confidential information of the Commission shall remain confidential after such information is provided to any Commissioner.

(3) The Commission shall monitor Compacting States for compliance with duly adopted Bylaws, Rules, including Uniform Standards, and Operating Procedures. The Commission shall notify any noncomplying Compacting State in writing of its noncompliance with Commission Bylaws, Rules or Operating Procedures. If a noncomplying Compacting State fails to remedy its noncompliance within the time specified in the notice of noncompliance, the Compacting State shall be deemed to be in default as set forth in Article XIV.

(4) The Commissioner of any State in which an Insurer is authorized to do business, or is conducting the business of insurance, shall continue to exercise his or her authority to oversee the market regulation of the activities of the Insurer in accordance with the provisions of the State's law. The Commissioner's enforcement of compliance with the Compact is governed by the following provisions:

(a) With respect to the Commissioner's market regulation of a Product or Advertisement that is approved or certified to the Commission, the content of the Product or Advertisement shall not constitute a violation of the provisions, standards, or requirements of the Compact except upon a final order of the Commission, issued at the request of a Commissioner after prior notice to the Insurer and an opportunity for hearing before the Commission.

(b) Before a Commissioner may bring an action for violation of any provision, standard, or requirement of the Compact relating to the content of an Advertisement not approved or certified to the Commission, the Commission, or an authorized Commission officer or employee, must authorize the action. However, authorization pursuant to this paragraph does not require notice to the Insurer, opportunity for hearing or disclosure of requests for authorization or records of the Commission's action on such requests.

Article IX. Dispute Resolution.

The Commission shall attempt, upon the request of a Member, to resolve any disputes or other issues that are subject to this Compact

and which may arise between two or more Compacting States, or between Compacting States and Noncompacting States, and the Commission shall promulgate an Operating Procedure providing for resolution of such disputes.

Article X. Product Filing and Approval.

(1) Insurers and Third-Party Filers seeking to have a Product approved by the Commission shall file the Product with, and pay applicable filing fees to, the Commission. Nothing in this Act shall be construed to restrict or otherwise prevent an insurer from filing its Product with the insurance department in any State wherein the insurer is licensed to conduct the business of insurance, and such filing shall be subject to the laws of the States where filed.

(2) The Commission shall establish appropriate filing and review processes and procedures pursuant to Commission Rules and Operating Procedures. Notwithstanding any provision herein to the contrary, the Commission shall promulgate Rules to establish conditions and procedures under which the Commission will provide public access to Product filing information. In establishing such Rules, the Commission shall consider the interests of the public in having access to such information, as well as protection of personal medical and financial information and trade secrets, that may be contained in a Product filing or supporting information.

(3) Any Product approved by the Commission may be sold or otherwise issued in those Compacting States for which the Insurer is legally authorized to do business.

Article XI. Review of Commission Decisions Regarding Filings.

(1) Not later than thirty (30) days after the Commission has given notice of a disapproved Product or Advertisement filed with the Commission, the Insurer or Third Party Filer whose filing was disapproved may appeal the determination to a review panel appointed by the Commission. The Commission shall promulgate Rules to establish procedures for appointing such review panels and provide for notice and hearing. An allegation that the Commission, in disapproving a Product or Advertisement filed with the Commission, acted arbitrarily, capriciously, or in a manner that is an abuse of discretion or otherwise not in accordance with the law, is subject to judicial review in accordance with Article III, Section (4).

(2) The Commission shall have authority to monitor, review, and reconsider Products and Advertisement subsequent to their filing or approval upon a finding that the product does not meet the relevant Uniform Standard. Where appropriate, the Commission may withdraw or modify its approval after proper notice and hearing, subject to the appeal process in Section (1) above.

Article XII. Finance.

(1) The Commission shall pay or provide for the payment of the reasonable expenses of its establishment and organization. To fund the cost of its initial operations, the Commission may accept contributions and other forms of funding from the National Association of Insurance Commissioners, Compacting States, and other sources. Contributions and other forms of funding from other sources shall be of such a nature that the independence of the Commission concerning the performance of its duties shall not be compromised.

(2) The Commission shall collect a filing fee from each Insurer and Third Party Filer filing a product with the Commission to cover the cost of the operations and activities of the Commission and its staff in a total amount sufficient to cover the Commission's annual budget.

(3) The Commission's budget for a fiscal year shall not be approved until it has been subject to notice and comment as set forth in Article VII of this Compact.

(4) The Commission shall be exempt from all taxation in and by the Compacting States.

(5) The Commission shall not pledge the credit of any Compacting State, except by and with the appropriate legal authority of that Compacting State.

(6) The Commission shall keep complete and accurate accounts of all its internal receipts, including grants and donations, and disbursements of all funds under its control. The internal financial accounts of the Commission shall be subject to the accounting procedures established under its Bylaws. The financial accounts and reports including the system of internal controls and procedures of the Commission shall be audited annually by an independent certified public accountant. Upon the determination of the Commission, but no less frequently than every three (3) years, the review of the independent auditor shall include a management and performance audit of the Commission. The Commission shall make an Annual Report to the Governor and legislature of the Compacting States, which shall include a report of the independent audit. The Commission's internal accounts shall not be confidential and such materials may be shared with the Commissioner of any Compacting State upon request provided, however, that any work papers related to any internal or independent audit and any information regarding the privacy of individuals and insurers' proprietary information, including trade secrets, shall remain confidential.

(7) No Compacting State shall have any claim to or ownership of any property held by or vested in the Commission or to any Commission funds held pursuant to the provisions of this Compact.

Article XIII. Compacting States, Effective Date, and Amendment.

(1) Any State is eligible to become a Compacting State.

(2) The Compact shall become effective and binding upon legislative enactment of the Compact into law by two Compacting States; provided, the Commission shall become effective for purposes of adopting Uniform Standards for, reviewing, and giving approval or disapproval of, Products filed with the Commission that satisfy applicable Uniform Standards only after twenty-six (26) States are Compacting States or, alternatively, by States representing greater than forty percent (40%) of the premium volume for life insurance, annuity, disability income, and long-term care insurance products, based on records of the NAIC for the prior year. Thereafter, it shall become effective and binding as to any other Compacting State upon enactment of the Compact into law by that State.

(3) Amendments to the Compact may be proposed by the Commission for enactment by the Compacting States. No amendment shall become effective and binding upon the Commission and the Compacting States unless and until all Compacting States enact the amendment into law.

Article XIV. Withdrawal, Default, and Termination.

(1) Withdrawal.

(a) Once effective, the Compact shall continue in force and remain binding upon each and every Compacting State; provided, that a Compacting State may withdraw from the Compact ("Withdrawing State") by enacting a statute specifically repealing the statute which enacted the Compact into law.

(b) The effective date of withdrawal is the effective date of the repealing statute. However, the withdrawal shall not apply to any product filings approved or self-certified, or any Advertisement of such products, on the date the repealing statute becomes effective, except by mutual agreement of the Commission and the Withdrawing State unless the approval is rescinded by the Withdrawing State as provided in Paragraph (e) of this section.

(c) The Commissioner of the Withdrawing State shall immediately notify the Management Committee in writing upon the introduction of legislation repealing this Compact in the Withdrawing State.

(d) The Commission shall notify the other Compacting States of the introduction of such legislation within ten (10) days after its receipt of notice thereof.

(e) The Withdrawing State is responsible for all obligations, duties, and liabilities incurred through the effective date of withdrawal,

including any obligations, the performance of which extend beyond the effective date of withdrawal, except to the extent those obligations may have been released or relinquished by mutual agreement of the Commission and the Withdrawing State. The Commission's approval of Products and Advertisement prior to the effective date of withdrawal shall continue to be effective and be given full force and effect in the Withdrawing State, unless formally rescinded by the Withdrawing State in the same manner as provided by the laws of the Withdrawing State for the prospective disapproval of products or advertisement previously approved under state law.

(f) Reinstatement following withdrawal of any Compacting State shall occur upon the effective date of the Withdrawing State reenacting the Compact.

(2) Default.

(a) If the Commission determines that any Compacting State has at any time defaulted ("Defaulting State") in the performance of any of its obligations or responsibilities under this Compact, the Bylaws or duly promulgated Rules or Operating Procedures, then, after notice and hearing as set forth in the Bylaws, all rights, privileges, and benefits conferred by this Compact on the Defaulting State shall be suspended from the effective date of default as fixed by the Commission. The grounds for default include, but are not limited to, failure of a Compacting State to perform its obligations or responsibilities, and any other grounds designated in Commission Rules. The Commission shall immediately notify the Defaulting State in writing of the Defaulting State's suspension pending a cure of the default. The Commission shall stipulate the conditions and the time period within which the Defaulting State must cure its default. If the Defaulting State fails to cure the default within the time period specified by the Commission, the Defaulting State shall be terminated from the Compact and all rights, privileges, and benefits conferred by this Compact shall be terminated from the effective date of termination.

(b) Product approvals by the Commission or product self-certifications, or any Advertisement in connection with such product, that are in force on the effective date of termination shall remain in force in the Defaulting State in the same manner as if the Defaulting State had withdrawn voluntarily pursuant to Section (1) of this article.

(c) Reinstatement following termination of any Compacting State requires a reenactment of the Compact.

(3) Dissolution of Compact.

(a) The Compact dissolves effective upon the date of the withdrawal or default of the Compacting State which reduces membership in the Compact to one Compacting State.

(b) Upon the dissolution of this Compact, the Compact becomes null and void and shall be of no further force or effect, and the business and affairs of the Commission shall be wound up and any surplus funds shall be distributed in accordance with the Bylaws.

Article XV. Severability and Construction.

(1) The provisions of this Compact shall be severable; and if any phrase, clause, sentence, or provision is deemed unenforceable, the remaining provisions of the Compact shall be enforceable.

(2) The provisions of this Compact shall be liberally construed to effectuate its purposes.

Article XVI. Binding Effect of Compact and Other Laws.

(1) Other Laws.

(a) Nothing herein prevents the enforcement of any other law of a Compacting State, except as provided in Paragraph (b) of this section.

(b) For any Product approved or certified to the Commission, the Rules, Uniform Standards, and any other requirements of the Commission shall constitute the exclusive provisions applicable to the content, approval, and certification of such Products. For Advertisement that is subject to the Commission's authority, any Rule, Uniform Standard, or other requirement of the Commission which governs the content of the Advertisement shall constitute the exclusive provision that a Commissioner may apply to the content of the Advertisement. Notwithstanding the foregoing, no action taken by the Commission shall abrogate or restrict: (i) the access of any person to state courts; (ii) remedies available under state law related to breach of contract, tort, or other laws not specifically directed to the content of the Product; (iii) state law relating to the construction of insurance contracts; or (iv) the authority of the attorney general of the state, including, but not limited to, maintaining any actions or proceedings, as authorized by law.

(c) All insurance products filed with individual States shall be subject to the laws of those States.

(2) Binding Effect of this Compact.

(a) All lawful actions of the Commission, including all Rules and Operating Procedures promulgated by the Commission, are binding upon the Compacting States.

(b) All agreements between the Commission and the Compacting States are binding in accordance with their terms.

(c) Upon the request of a party to a conflict over the meaning or interpretation of Commission actions, and upon a majority vote of the Compacting States, the Commission may issue advisory opinions regarding the meaning or interpretation in dispute.

(d) In the event any provision of this Compact exceeds the constitutional limits imposed on the legislature of any Compacting State, the obligations, duties, powers, or jurisdiction sought to be conferred by that provision upon the Commission shall be ineffective as to that Compacting State, and those obligations, duties, powers, or jurisdiction shall remain in the Compacting State and shall be exercised by the agency thereof to which those obligations, duties, powers, or jurisdiction are delegated by law in effect at the time this Compact becomes effective. (Code 1981, § 33-59A-1, enacted by Ga. L. 2006, p. 1033, § 1/SB 384.)

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2006, Code Section 33-59-1, as enacted by Ga. L. 2006, p. 1033, § 1/SB 384, was redesignated as Code Section 33-59A-1.

33-59A-2. Membership on Interstate Insurance Product Regulation Commission; Commissioner of Insurance to be state’s representative.

Pursuant to terms and conditions of this chapter, the State of Georgia seeks to join with other states and establish the Interstate Insurance Product Regulation Compact, and thus become a member of the Interstate Insurance Product Regulation Commission. The Commissioner of Insurance is hereby designated to serve as the representative of the State of Georgia to the commission. (Code 1981, § 33-59A-2, enacted by Ga. L. 2006, p. 1033, § 1/SB 384; Ga. L. 2007, p. 47, § 33/SB 103.)

The 2007 amendment, effective May 11, 2007, part of an Act to revise, modernize, and correct the Code, revised language in this Code section.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2006, Code Section 33-59-2, as enacted by Ga. L. 2006, p. 1033, § 1/SB 384, was redesignated as Code Section 33-59A-2.

CHAPTER 61

REGULATION OF AUTOMOBILE CLUBS

- Sec.
- 33-61-1. Definitions.
- 33-61-2. Automobile club performing services.

Effective date. — This chapter became effective April 21, 2006.

33-61-1. Definitions.

As used in this chapter, the term:

(1) “Automobile club” or “club” means any person, who in consideration of fees, dues, periodic payments, or other specifically stated charges, promises its members to provide automobile club services.

(2) “Automobile club services” shall include, but not be limited to, the assumption of or reimbursement of the expense or a portion thereof for towing of a motor vehicle, emergency road service, matters relating to the operation, use, and maintenance of a motor vehicle, and the supplying of services which includes, augments, or is incidental to theft or reward services, discount services, arrest bond services, lock and key services, trip interruption services, and legal fee reimbursement services in defense of traffic related offenses.

(3) “Commissioner” shall mean the Commissioner of Insurance of the State of Georgia. (Code 1981, § 33-61-1, enacted by Ga. L. 2006, p. 331, § 1/HB 1291.)

33-61-2. Automobile club performing services.

An automobile club performing services as defined in this chapter shall not be subject to any laws respecting insurance companies of any class, kind, or character in this state or regulation under such laws because of performance of those services. (Code 1981, § 33-61-2, enacted by Ga. L. 2006, p. 331, § 1/HB 1291.)

CHAPTER 62

**PROPERTY AND CASUALTY ACTUARIAL OPINION
LAW**

Sec.		Sec.	
33-62-1.	Short title.		nies licensed to do business in Georgia.
33-62-2.	Submission of annual statement of actuarial opinion of appointed actuary by property and casualty insurance compa-	33-62-3.	Submission of supporting documentation; confidentiality; disclosure.

Effective date. — This chapter became effective January 1, 2010. **Code Commission notes.** — Pursuant to Code Section 28-9-5, in 2008, Ch. 62, T.

33, as enacted by Ga. L. 2008, p. 1097, § 1, was redesignated as Ch. 63, T. 33.

33-62-1. Short title.

This chapter shall be known and may be cited as the “Property and Casualty Actuarial Opinion Law.” (Code 1981, § 33-62-1, enacted by Ga. L. 2008, p. 1090, § 4/SB 471.)

33-62-2. Submission of annual statement of actuarial opinion of appointed actuary by property and casualty insurance companies licensed to do business in Georgia.

(a) Every property and casualty insurance company doing business in this state, unless otherwise exempted by the domiciliary commissioner, shall annually submit the opinion of an appointed actuary entitled “Statement of Actuarial Opinion.” This opinion shall be filed in accordance with rules and regulations promulgated by the Commissioner regarding property and casualty annual statement instructions.

(b)(1) Every property and casualty insurance company domiciled in this state that is required to submit a statement of actuarial opinion shall annually submit an actuarial opinion summary written by the company’s appointed actuary. This actuarial opinion summary shall be filed in accordance with rules and regulations promulgated by the Commissioner regarding property and casualty annual statement instructions and shall be considered as a document supporting the actuarial opinion required in subsection (a) of this Code section.

(2) A company licensed but not domiciled in this state shall provide the actuarial opinion summary upon request.

(c)(1) An actuarial report and underlying work papers as required by rules and regulations promulgated by the Commissioner regarding property and casualty annual statement instructions shall be prepared to support each actuarial opinion.

(2) If the insurance company fails to provide a supporting actuarial report or work papers at the request of the Commissioner or the Commissioner determines that the supporting actuarial report or work papers provided by the insurance company are otherwise unacceptable to the Commissioner, the Commissioner may engage a qualified actuary at the expense of the insurance company to review the opinion and the basis for the opinion and prepare the supporting actuarial report or work papers.

(d) The appointed actuary shall not be liable for damages to any person other than the insurance company and the Commissioner for any act, error, omission, decision, or conduct with respect to the

actuary's opinion except in cases of fraud or willful misconduct on the part of the appointed actuary. (Code 1981, § 33-62-2, enacted by Ga. L. 2008, p. 1090, § 4/SB 471.)

33-62-3. Submission of supporting documentation; confidentiality; disclosure.

(a) The statement of actuarial opinion shall be provided with the annual statement in accordance with rules and regulations promulgated by the Commissioner regarding property and casualty annual statement instructions and shall be treated as a public document.

(b)(1) Documents, materials, or other information in the possession or control of the department that are considered an actuarial report, work papers, or actuarial opinion summary provided in support of the opinion and any other material provided by the insurance company to the Commissioner in connection with the actuarial report, work papers, or the actuarial opinion summary shall be confidential by law and privileged, shall not be subject to disclosure under Article 4 of Chapter 18 of Title 50, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

(2) The provisions of this subsection shall not be construed to limit the Commissioner's authority to release the documents to the Actuarial Board for Counseling and Discipline so long as the material is required for the purpose of professional disciplinary proceedings and that the Actuarial Board for Counseling and Discipline establishes procedures satisfactory to the Commissioner for preserving the confidentiality of the documents. In addition, the provisions of this subsection shall not be construed to limit the Commissioner's authority to use the documents, materials, or other information in furtherance of any regulatory or legal action brought as a part of the Commissioner's official duties.

(c) Neither the Commissioner nor any person who received documents, materials, or other information while acting under the authority of the Commissioner shall be permitted or required to testify in any private civil action concerning such confidential documents, materials, or other information subject to subsection (b) of this Code section.

(d) In order to assist the Commissioner in the performance of his or her duties, the Commissioner may:

(1) Share documents, materials, and other information, including confidential and privileged documents, materials, and information subject to subsection (b) of this Code section with other state, federal, and international regulatory agencies, with the National Association

of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal, and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, or other information and has the legal authority to maintain confidentiality;

(2) Receive documents, materials, and other information, including otherwise confidential and privileged documents, materials, or information, from the National Association of Insurance Commissioners and its affiliates and subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions. The Commissioner shall maintain as confidential and privileged any document, material, or information received with notice and the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information; and

(3) Enter into agreements concerning sharing and use of information consistent with this subsection and subsections (b) and (c) of this Code section.

(e) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the Commissioner under this Code section or as a result of sharing as authorized by subsection (d) of this Code section. (Code 1981, § 33-62-3, enacted by Ga. L. 2008, p. 1090, § 4/SB 471.)

CHAPTER 63

GUARANTEED ASSET PROTECTION WAIVERS

Sec.		Sec.	
33-63-1.	Legislative findings.	33-63-5.	Contractual liability or other insurance policies.
33-63-2.	Purpose; exemptions from applicability of chapter; guaranteed asset protection waivers exempt from state's insurance laws.	33-63-6.	Required disclosures.
33-63-3.	Definitions.	33-63-7.	Cancellation.
33-63-4.	Offering, selling, or providing to borrowers guaranteed asset protection waivers.	33-63-8.	Exempted commercial transactions.
		33-63-9.	Commissioner of Insurance to enforce provisions; penalty for violations.

Effective date. — This chapter became effective July 1, 2008. 33, as enacted by Ga. L. 2008, p. 1097, § 1, was redesignated as Ch. 63, T. 33.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2008, Ch. 62, T. **Editor's notes.** — Ga. L. 2008, p. 1097, § 2, not codified by the General Assembly,

provides: "This Act shall become effective on July 1, 2008, and apply to all guaranteed asset protection waivers which shall become effective on or after January 1, 2009."

33-63-1. Legislative findings.

The General Assembly finds that guaranteed asset protection waivers are not insurance. All guaranteed asset protection waivers issued after the date of enactment of this chapter shall not be construed as insurance. (Code 1981, § 33-63-1, enacted by Ga. L. 2008, p. 1097, § 1/SB 470.)

33-63-2. Purpose; exemptions from applicability of chapter; guaranteed asset protection waivers exempt from state's insurance laws.

(a) The purpose of this chapter is to provide a framework within which guaranteed asset protection waivers are defined and may be offered within this state.

(b) This chapter shall not apply to:

(1) An insurance policy offered by an insurer under the insurance laws of this state; or

(2) A debt cancellation or debt suspension contract being offered in compliance with 12 C.F.R. Part 37 or 12 C.F.R. Part 721 or other federal law.

(c) Guaranteed asset protection waivers governed under this chapter are not insurance and are exempt from the insurance laws of this state. Persons marketing, selling, or offering to sell guaranteed asset protection waivers to borrowers that comply with this chapter are exempt from this state's insurance licensing requirements. (Code 1981, § 33-63-2, enacted by Ga. L. 2008, p. 1097, § 1/SB 470.)

33-63-3. Definitions.

The following terms are defined for purposes of this chapter and are not intended to provide actual terms required in guaranteed asset protection waivers:

(1) "Administrator" means a person, other than an insurer or creditor, that performs administrative or operational functions pursuant to guaranteed asset protection waiver programs.

(2) "Borrower" means a debtor, retail buyer, or lessee under a finance agreement.

(3) "Creditor" means:

(A) The lender in a loan or credit transaction;

(B) The lessor in a lease transaction;

(C) Any retail installment seller that provides credit to any retail buyer of motor vehicles, provided that such entity complies with the provisions of this chapter;

(D) The seller in commercial retail installment transactions; or

(E) The assignees of any of the creditors listed in subparagraphs (A) through (D) of this paragraph to whom the credit obligation is payable.

(4) “Finance agreement” means a loan, lease, or retail installment sales contract for the purchase or lease of a motor vehicle.

(5) “Free look period” means the period of time from the effective date of the guaranteed asset protection waiver until the date the borrower may cancel the guaranteed asset protection waiver without penalty, fees, or costs to the borrower. This period of time must not be shorter than 30 days.

(6) “Guaranteed asset protection waiver” means a contractual agreement wherein a creditor agrees for a separate charge to cancel or waive all or part of amounts due on a borrower’s finance agreement in the event of a total physical damage loss or unrecovered theft of the motor vehicle, which agreement must be part of, or a separate addendum to, the finance agreement.

(7) “Insurer” means an insurance company licensed, registered, or otherwise authorized to do business under the insurance laws of this state.

(8) “Motor vehicle” means self-propelled or towed vehicles designed for personal or commercial use, including but not limited to automobiles, trucks, motorcycles, recreational vehicles, all-terrain vehicles, campers, boats, personal watercraft, and motorcycle, boat, camper, and personal watercraft trailers.

(9) “Person” includes an individual, company, association, organization, partnership, business trust, corporation, and every form of legal entity.

(10) “Retail buyer” shall have the same meaning as provided in Code Section 10-1-31.

(11) “Retail installment seller” shall have the same meaning as provided in Code Section 10-1-31. (Code 1981, § 33-63-3, enacted by Ga. L. 2008, p. 1097, § 1/SB 470.)

33-63-4. Offering, selling, or providing to borrowers guaranteed asset protection waivers.

(a) Guaranteed asset protection waivers may be offered, sold, or provided to borrowers in this state in compliance with this chapter.

(b) Guaranteed asset protection waivers may, at the option of the creditor, be sold for a single payment or may be offered with a monthly or periodic payment option.

(c) Notwithstanding any other provision of law, any cost to the borrower for a guaranteed asset protection waiver entered into in compliance with the federal Truth in Lending Act, 15 U.S.C. Section 1601, et seq., and its implementing regulations, as they may be amended from time to time, must be separately stated and is not to be considered a finance charge or interest.

(d) A retail installment seller must insure its guaranteed asset protection waiver obligations under a contractual liability or other insurance policy issued by an insurer. A creditor other than a retail installment seller may insure its guaranteed asset protection waiver obligations under a contractual liability policy or other such policy issued by an insurer. Any such insurance policy may be directly obtained by a creditor or retail installment seller or may be procured by an administrator to cover a creditor's or retail installment seller's obligations. However, retail installment sellers that are lessors on motor vehicles are not required to insure obligations related to guaranteed asset protection waivers on such leased vehicles.

(e) The guaranteed asset protection waiver shall remain a part of the finance agreement upon the assignment, sale, or transfer of such finance agreement by the creditor.

(f) Neither the extension of credit, the term of credit, nor the term of the related motor vehicle sale or lease may be conditioned upon the purchase of a guaranteed asset protection waiver.

(g) Any creditor that offers a guaranteed asset protection waiver must report the sale of, and forward funds received on, all such waivers to the designated party, if any, as prescribed in any applicable administrative services agreement, contractual liability policy, other insurance policy or other specified program documents.

(h) Funds received or held by a creditor or administrator and belonging to an insurer, creditor, or administrator pursuant to the terms of a written agreement must be held by such creditor or administrator in a fiduciary capacity.

(i) A retail installment seller that offers, provides, or sells a guaranteed asset protection waiver in connection with the sale of a motor

vehicle shall not be required to insure its guaranteed asset protection waiver if the retail installment seller does both of the following:

(1) Maintains, or has a parent company that maintains, a net worth or stockholders' equity of at least \$50 million, provided the parent company guarantees the obligations of the retail installment seller arising from guaranteed asset protection waivers underwritten pursuant to this subsection; and

(2) Files a copy of its Form 10-K or Form 20-F disclosure statements, or, if it does not file with the United States Securities and Exchange Commission, a copy of its audited financial statements reported on generally accepted accounting principles. If the retail installment seller's financial statements are consolidated with those of its parent company, then the retail installment seller may comply with the provisions of this paragraph by filing the statements of its parent company. The statement shall be filed with the Commissioner at least 30 days prior to the retail installment seller's initial offering or delivering a guaranteed asset protection waiver, and thereafter the statement shall be filed with the Commissioner annually. (Code 1981, § 33-63-4, enacted by Ga. L. 2008, p. 1097, § 1/SB 470; Ga. L. 2009, p. 8, § 33/SB 46; Ga. L. 2012, p. 1350, § 11/HB 1067.)

The 2009 amendment, effective April 14, 2009, part of an Act to revise, modernize, and correct the Code, revised punctuation in subsection (c).

The 2012 amendment, effective July 1, 2012, added subsection (i).

33-63-5. Contractual liability or other insurance policies.

(a) Contractual liability or other insurance policies insuring guaranteed asset protection waivers must state the obligation of the insurer to reimburse or pay to the creditor any sums the creditor is legally obligated to waive under the guaranteed asset protection waivers issued by the creditor and purchased or held by the borrower.

(b) Coverage under a contractual liability or other insurance policy insuring a guaranteed asset protection waiver must also cover any subsequent assignee upon the assignment, sale, or transfer of the finance agreement.

(c) Coverage under a contractual liability or other insurance policy insuring a guaranteed asset protection waiver must remain in effect unless cancelled or terminated in compliance with the applicable insurance laws of this state.

(d) The cancellation or termination of a contractual liability or other insurance policy must not reduce the insurer's responsibility for guaranteed asset protection waivers issued by the creditor prior to the date of cancellation or termination and for which premium has been received

by the insurer. (Code 1981, § 33-63-5, enacted by Ga. L. 2008, p. 1097, § 1/SB 470.)

33-63-6. Required disclosures.

Guaranteed asset protection waivers must disclose, as applicable, in writing and in clear, understandable language that is easy to read, the following:

(1) The name and address of the initial creditor and the borrower at the time of sale and the identity of any administrator if different from the creditor;

(2) The purchase price and the terms of the guaranteed asset protection waiver, including without limitation the requirements for protection, conditions, or exclusions associated with the guaranteed asset protection waiver;

(3) That the borrower may cancel the guaranteed asset protection waiver within a free look period, as specified in the waiver, and will be entitled to a full refund of the purchase price, provided no benefits have been made; or in the event benefits have been made, the borrower may receive a full or partial refund if the waiver so provides;

(4) The procedure the borrower must follow, if any, to obtain guaranteed asset protection waiver benefits under the terms and conditions of the waiver, including a telephone number and address where the borrower may apply for waiver benefits;

(5) Whether or not the guaranteed asset protection waiver is cancelable after the free look period and the conditions under which it may be canceled or terminated, including the procedures for requesting any refund due;

(6) That in order to receive any refund due in the event of a borrower's cancellation of the guaranteed asset protection waiver agreement or early termination of the finance agreement after the free look period of the guaranteed asset protection waiver, the borrower, in accordance with terms of the waiver, must provide a written request to cancel to the creditor, administrator, or such other party within 90 days after the borrower's decision to cancel the waiver or the occurrence of the event terminating the finance agreement;

(7) The methodology for calculating any refund of the unearned purchase price of the guaranteed asset protection waiver due in the event of cancellation of the guaranteed asset protection waiver or early termination of the finance agreement; and

(8) That neither the extension of credit, the terms of the credit, nor the terms of the related motor vehicle sale or lease may be conditioned upon the purchase of the guaranteed asset protection waiver. (Code 1981, § 33-63-6, enacted by Ga. L. 2008, p. 1097, § 1/SB 470.)

33-63-7. Cancellation.

(a) Guaranteed asset protection waiver agreements may be cancelable or noncancelable after the free look period. Guaranteed asset protection waivers must provide that if a borrower cancels a waiver within the free look period, the borrower will be entitled to a full refund of the purchase price, provided no benefits have been paid; or in the event benefits have been paid, the borrower may receive a full or partial refund if the waiver so provides.

(b) In the event of a borrower's cancellation of the guaranteed asset protection waiver or early termination of the finance agreement, after the agreement has been in effect beyond the free look period, the borrower may be entitled to a refund of any unearned portion of the purchase price of the waiver unless the waiver provides otherwise. In order to receive a refund, the borrower, in accordance with any applicable terms of the waiver, must provide a written request to the creditor, administrator, or other party within 90 days after the borrower's decision to cancel the waiver or the occurrence of the event terminating the finance agreement.

(c) If the cancellation of a guaranteed asset protection waiver occurs as a result of a default under the finance agreement or the repossession of the motor vehicle associated with the finance agreement, or any other termination of the finance agreement, any refund due may be paid directly to the creditor or administrator and applied as set forth in subsection (d) of this Code section.

(d) Any cancellation refund under subsection (a), (b), or (c) of this Code section may be applied by the creditor as a reduction of the amount owed under the finance agreement unless the borrower can show that the finance agreement has been paid in full. (Code 1981, § 33-63-7, enacted by Ga. L. 2008, p. 1097, § 1/SB 470.)

33-63-8. Exempted commercial transactions.

Subsection (c) of Code Section 33-63-4 and Code Sections 33-63-6 and 33-63-9 shall not be applicable to a guaranteed asset protection waiver offered in connection with a lease or retail installment sale associated with a commercial transaction. (Code 1981, § 33-63-8, enacted by Ga. L. 2008, p. 1097, § 1/SB 470.)

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2008, “33-63-4”, “33-63-6”, and “33-63-9” were substituted for “33-62-4”, “33-62-6”, and “33-62-9”, respectively.

33-63-9. Commissioner of Insurance to enforce provisions; penalty for violations.

The Commissioner of Insurance may take action which is necessary or appropriate to enforce the provisions of this chapter and to protect guaranteed asset protection waiver holders in this state. After proper notice and opportunity for hearing, the commissioner may:

- (1) Order the creditor, administrator, or any other person not in compliance with this chapter to cease and desist from further guaranteed asset protection waiver related operations which are in violation of this chapter; and
- (2) Impose a penalty of not more than \$500.00 per violation and not more than \$10,000.00 in the aggregate for all violations of similar nature. For purposes of this paragraph, violations must be of a similar nature if the violation consists of the same or similar course of conduct, action, or practice, irrespective of the number of times the conduct, action, or practice which is determined to be a violation of this chapter occurred. (Code 1981, § 33-63-9, enacted by Ga. L. 2008, p. 1097, § 1/SB 470.)

CHAPTER 64

REGULATION AND LICENSURE OF PHARMACY BENEFITS MANAGERS

Sec.	Sec.
33-64-1. Definitions.	33-64-6. Pharmacy benefits manager shall not have to be licensed as an administrator.
33-64-2. License requirements and filing fees.	33-64-7. Commissioner not authorized to extend rules and regulations.
33-64-3. Requirements and procedures affecting pharmacy benefits managers; surety bond.	33-64-8. Electronic prior authorization drug requests with health care providers.
33-64-4. Pharmacy benefits manager shall not engage in the practice of medicine.	
33-64-5. Audit requirements applicable to pharmacy benefits managers.	

Effective date. — This chapter became effective January 15, 2011.

33-64-1. Definitions.

As used in this chapter, the term:

(1) “Business entity” means a corporation, association, partnership, sole proprietorship, limited liability company, limited liability partnership, or other legal entity.

(2) “Commissioner” means the Commissioner of Insurance.

(3) “Covered entity” means an employer, labor union, or other group of persons organized in this state that provides health coverage to covered individuals who are employed or reside in this state.

(4) “Covered individual” means a member, participant, enrollee, contract holder, policy holder, or beneficiary of a covered entity who is provided health coverage by a covered entity.

(5) “Health system” means a hospital or any other facility or entity owned, operated, or leased by a hospital and a long-term care home.

(6) “Pharmacy benefits management” means the service provided to a health plan or covered entity, directly or through another entity, including the procurement of prescription drugs to be dispensed to patients, or the administration or management of prescription drug benefits, including, but not limited to, any of the following:

(A) Mail service pharmacy;

(B) Claims processing, retail network management, or payment of claims to pharmacies for dispensing prescription drugs;

(C) Clinical or other formulary or preferred drug list development or management;

(D) Negotiation or administration of rebates, discounts, payment differentials, or other incentives for the inclusion of particular prescription drugs in a particular category or to promote the purchase of particular prescription drugs;

(E) Patient compliance, therapeutic intervention, or generic substitution programs; and

(F) Disease management.

(7) “Pharmacy benefits manager” means a person, business entity, or other entity that performs pharmacy benefits management. The term includes a person or entity acting for a pharmacy benefits manager in a contractual or employment relationship in the performance of pharmacy benefits management for a covered entity. The

term does not include services provided by pharmacies operating under a hospital pharmacy license. The term also does not include health systems while providing pharmacy services for their patients, employees, or beneficiaries, for indigent care, or for the provision of drugs for outpatient procedures. (Code 1981, § 33-64-1, enacted by Ga. L. 2010, p. 757, § 1/SB 310.)

33-64-2. License requirements and filing fees.

(a) No person, business entity, or other entity shall act as or hold itself out to be a pharmacy benefits manager in this state, other than an applicant licensed in this state for the kinds of business for which it is acting as a pharmacy benefits manager, unless such person, business entity, or other entity holds a license as a pharmacy benefits manager issued by the Commissioner pursuant to this chapter. The license shall be renewable on an annual basis. Failure to hold such license shall subject such person, business entity, or other entity to the fines and other appropriate penalties as provided in Chapter 2 of this title.

(b) An application for a pharmacy benefits manager's license or an application for renewal of such license shall be accompanied by a filing fee of \$500.00 for an initial license and \$400.00 for renewal.

(c) A license shall be issued or renewed and shall not be suspended or revoked by the Commissioner unless the Commissioner finds that the applicant for or holder of the license:

(1) Has intentionally misrepresented or concealed any material fact in the application for the license;

(2) Has obtained or attempted to obtain the license by misrepresentation, concealment, or other fraud;

(3) Has committed fraud; or

(4) Has failed to obtain for initial licensure or retain for annual licensure renewal a net worth of at least \$200,000.00.

(d) If the Commissioner moves to suspend, revoke, or nonrenew a license for a pharmacy benefits manager, the Commissioner shall provide notice of that action to the pharmacy benefits manager, and the pharmacy benefits manager may invoke the right to an administrative hearing in accordance with Chapter 2 of this title.

(e) No licensee whose license has been revoked as prescribed under this Code section shall be entitled to file another application for a license within five years from the effective date of the revocation or, if judicial review of such revocation is sought, within five years from the date of final court order or decree affirming the revocation. The application when filed may be refused by the Commissioner unless the

applicant shows good cause why the revocation of its license shall not be deemed a bar to the issuance of a new license.

(f) Appeal from any order or decision of the Commissioner made pursuant to this chapter shall be taken as provided in Chapter 2 of this title.

(g)(1) The Commissioner shall have the authority to issue a probationary license to any applicant under this title.

(2) A probationary license may be issued for a period of not less than three months and not longer than 12 months and shall be subject to immediate revocation for cause at any time without a hearing.

(3) The Commissioner shall prescribe the terms of probation, may extend the probationary period, or refuse to grant a license at the end of any probationary period in accordance with rules and regulations.

(h) A pharmacy benefits manager's license may not be sold or transferred to a nonaffiliated or otherwise unrelated party. A pharmacy benefits manager may not contract or subcontract any of its negotiated formulary services to any unlicensed nonaffiliated business entity unless a special authorization is approved by the Commissioner prior to entering into a contracted or subcontracted arrangement.

(i) In addition to all other penalties provided for under this title, the Commissioner shall have the authority to assess a monetary penalty against any person, business entity, or other entity acting as a pharmacy benefits manager without a license of up to \$1,000.00 for each transaction in violation of this chapter, unless such person, business entity, or other entity knew or reasonably should have known it was in violation of this chapter, in which case the monetary penalty provided for in this subsection may be increased to an amount of up to \$5,000.00 for each and every act in violation.

(j) A licensed pharmacy benefits manager shall not market or administer any insurance product not approved in Georgia or that is issued by a nonadmitted insurer or unauthorized multiple employer self-insured health plan.

(k) In addition to all other penalties provided for under this title, the Commissioner shall have the authority to place any pharmacy benefits manager on probation for a period of time not to exceed one year for each and every act in violation of this chapter and may subject such pharmacy benefits manager to a monetary penalty of up to \$1,000.00 for each and every act in violation of this chapter, unless the pharmacy benefits manager knew or reasonably should have known he or she was in violation of this chapter, in which case the monetary penalty

provided for in this subsection may be increased to an amount of up to \$5,000.00 for each and every act in violation.

(l) A pharmacy benefits manager operating as a line of business or affiliate of a health insurer, health care center, hospital service corporation, medical service corporation, or fraternal benefit society licensed in this state or of any affiliate of such health insurer, health care center, hospital service corporation, medical service corporation, or fraternal benefit society shall not be required to obtain a license pursuant to this chapter. Such health insurer, health care center, hospital service corporation, medical service corporation, or fraternal benefit society shall notify the Commissioner annually, in writing, on a form provided by the Commissioner, that it is affiliated with or operating as a line of business as a pharmacy benefits manager. (Code 1981, § 33-64-2, enacted by Ga. L. 2010, p. 757, § 1/SB 310.)

33-64-3. Requirements and procedures affecting pharmacy benefits managers; surety bond.

(a) Every applicant for a pharmacy benefits manager's license shall file with the application and shall thereafter maintain in force a bond in the amount of \$100,000.00 in favor of the Commissioner executed by a corporate surety insurer authorized to transact insurance in this state. The terms and type of the bond shall be established by rules and regulations.

(b) The bond shall remain in force until the surety is released from liability by the Commissioner or until the bond is canceled by the surety. Without prejudice to any liability accrued prior to cancellation, the surety may cancel the bond upon 30 days' advance notice, in writing, filed with the Commissioner.

(c) Every applicant for a pharmacy benefits manager's license shall obtain and shall thereafter maintain in force errors and omissions coverage or other appropriate liability insurance, written by an insurer authorized to transact insurance in this state, in an amount of at least \$250,000.00.

(d) The coverage required in subsection (c) of this Code section shall remain in force for a term of at least one year and shall contain language that includes that the insurer may cancel the insurance upon 60 days' advance notice filed with the Commissioner. Other terms and conditions relating to the errors and omissions policy may be imposed on the applicant in accordance with rules and regulations.

(e) In the event a licensed pharmacy benefits manager fails to renew, surrenders, or otherwise terminates its license, it must retain both the bond and the errors and omissions coverage for a period of not less than

one year after the licensee has failed to renew, surrendered, or otherwise terminated the license. (Code 1981, § 33-64-3, enacted by Ga. L. 2010, p. 757, § 1/SB 310.)

33-64-4. Pharmacy benefits manager shall not engage in the practice of medicine.

No pharmacy benefits manager shall engage in the practice of medicine. (Code 1981, § 33-64-4, enacted by Ga. L. 2010, p. 757, § 1/SB 310.)

33-64-5. Audit requirements applicable to pharmacy benefits managers.

Pharmacy benefits managers, whether licensed pursuant to this chapter or exempt from licensure pursuant to subsection (l) of Code Section 33-64-2, shall be subject to Code Section 26-4-118, "The Pharmacy Audit Bill of Rights," to the same extent and in the same manner as pharmacies. (Code 1981, § 33-64-5, enacted by Ga. L. 2010, p. 757, § 1/SB 310.)

33-64-6. Pharmacy benefits manager shall not have to be licensed as an administrator.

A pharmacy benefits manager licensed pursuant to this chapter shall not be required to obtain a license as an administrator pursuant to Article 2 of Chapter 23 of this title to perform any function as a pharmacy benefits manager pursuant to this chapter. (Code 1981, § 33-64-6, enacted by Ga. L. 2010, p. 757, § 1/SB 310; Ga. L. 2011, p. 752, § 33/HB 142.)

The 2011 amendment, effective May 13, 2011, part of an Act to revise, modernize, and correct the Code, substituted "Article 2 of Chapter 23 of this title" for "Article 2 of Chapter 23 of Title 33" in this Code section.

33-64-7. Commissioner not authorized to extend rules and regulations.

The Commissioner may not enlarge upon or extend the provisions of this chapter through any act, rule, or regulation. (Code 1981, § 33-64-7, enacted by Ga. L. 2010, p. 757, § 1/SB 310.)

33-64-8. Electronic prior authorization drug requests with health care providers.

(a) As used in this Code section, "electronic prior authorization" or "e-prior authorization" means a requirement that a prescriber obtain

approval via electronic media from a health plan to prescribe a specific medication prior to dispensing. Facsimiles shall not be considered an electronic submission under this Code section except in the event that such electronic media is temporarily unavailable due to system failure or outage.

(b) No later than 24 months after the adoption of standards by the National Council of Prescription Drug Programs, the department shall under the direction of the Commissioner adopt standards by which the pharmacy benefits manager shall exchange standard e-prior authorization requests with health care providers for drugs and devices using electronic data interchange standards consistent with those adopted by the National Council of Prescription Drug Programs. Such standards shall support clinical workflow decision support of the physician provider.

(c) No later than 24 months after the adoption of standards by the National Council of Prescription Drug Programs, e-prior authorization requests shall be accessible and submitted by providers to pharmacy benefits managers and health plans through secure electronic transmissions utilizing the current National Council of Prescription Drug Programs electronic prior authorization standard.

(d) Nothing in this Code section shall require any health care provider to participate in e-prior authorization or electronic prior authorization in order to obtain the necessary authorization for patient care. (Code 1981, § 33-64-8, enacted by Ga. L. 2012, p. 1134, § 1/SB 416.)

Effective date. — This Code section became effective July 1, 2012.

